

**BOULDER THERAPY
INTAKE INFORMATION**

C O N F I D E N T I A L

Client Information

NAME: _____ Date: _____

DOB: _____ Age: _____ SSN: _____

Address: _____
Street City State Zip

Phone: Home (_____) _____ Is it ok to leave a phone message? (please circle) No Yes

Cell (_____) _____ Is it ok to leave a phone message? (please circle) No Yes

Please indicate other professionals, if any with whom you are currently working.

Name of Individual Therapist _____ Phone # _____

Name of Physician _____ Phone # _____

Other Professional _____ Phone # _____

Please circle appropriate categories:

Citizenship: United States Other _____

School Information:

School Name: _____ Major: _____

Class: Freshman Sophomore Junior Senior 5th Year Graduate Transfer Student

School Status: Full time Part time Continuing Education

Employment Information:

Employment: Full time Part time # of Hours/week _____

Employer: _____

Residence: With Family Alone Roommates Dorm Off-Campus Other: _____

Referred by: Self Family Friend Doctor Counselor Advisor Administrator
Name/or Other _____

Health Insurance Information

Insurance Company Name: _____

Phone number for Mental Health Benefits (usually on the back of the card): _____

Member ID number: _____

Financial Information

Financially Responsible Person:

Self Other (please specify) _____ Phone # _____

Emergency Contact:

Name: _____

Address: _____

Phone: _____ Relationship to you: _____

INTAKE QUESTIONNAIRE

If you are uncomfortable answering any questions on this form, you may leave them blank. At our initial appointment we can review your answers in greater depth, help clarify your goals, and determine together an appropriate course of action.

Name/or Other _____

Please describe yourself as fully as you feel comfortable:

How much reluctance to you have about coming in for therapy today? Please circle one:

No reluctance at all Very little reluctance Some reluctance Quite a bit of reluctance Strong reluctance

If more than one applies to you, please check all that apply:

Gender

- ___ Male
- ___ Female
- ___ Transgender
- ___ MTF
- ___ FTM
- ___ Intersex

Relationship Status

- ___ Single
- ___ Married or Partnered
- ___ Separated
- ___ Divorced
- ___ Widowed
- ___ Other _____

Sexual Orientation

- ___ Bi-Sexual
- ___ Gay or Lesbian
- ___ Heterosexual
- ___ Questioning

Ethnicity/Race

- ___ African-American
- ___ Arab American
- ___ Asian or ___ Pacific Islander
- ___ Caucasian, European-American
- ___ Chicano, Latino, Hispanic
- ___ Native or ___ Alaskan Native
- ___ Other _____

Religious affiliation/Spirituality:

Do you identify as having a disability? No Yes (please specify)

PRESENTING COMPLAINT:

Why are you coming in to see me?

Please check all issues that currently concern you (write the number 1 and 2 next to the two most important topics):

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual Health Issues |
| <input type="checkbox"/> Bipolar (Manic -Depression) | <input type="checkbox"/> Understanding Own Sexuality |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> coming-out process |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> sexual orientation |
| <input type="checkbox"/> Substance Use | <input type="checkbox"/> gender identity |
| <input type="checkbox"/> Eating /Body Image | <input type="checkbox"/> Adjusting to School/Work |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Improved Relationships with: |
| <input type="checkbox"/> Self-understanding | <input type="checkbox"/> Friends |
| <input type="checkbox"/> Self-acceptance | <input type="checkbox"/> Partner |
| <input type="checkbox"/> Self-care (hygiene, taking time for self) | <input type="checkbox"/> Family |
| <input type="checkbox"/> Good Decision Making | <input type="checkbox"/> Issues of Racial/Ethnic Identity |
| <input type="checkbox"/> Assertiveness | <input type="checkbox"/> Respecting Cultural Differences |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Understanding My Impact on Others |
| <input type="checkbox"/> Clarification of Own Values | <input type="checkbox"/> Decreasing Own Suicidal Thoughts |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Eliminating/Reducing Unhealthy Behavior |
| <input type="checkbox"/> Working Through a Traumatic Event(s) | <input type="checkbox"/> Academic/Work Problems |
| <input type="checkbox"/> Other (specify): | |

HISTORY OF PRESENTING COMPLAINT:

When did you start having a problem with this?

How have you coped so far?

What strengths do you bring to this problem which will assist you in overcoming it?

Please check all the following symptoms that you have experienced:

= Recent (within the last month)

= Past (one month ago or longer)

- | | |
|--|--|
| <input type="checkbox"/> <input type="radio"/> change in appetite | <input type="checkbox"/> <input type="radio"/> feelings of restlessness |
| <input type="checkbox"/> <input type="radio"/> significant weight gain/loss | <input type="checkbox"/> <input type="radio"/> trembling or shaking |
| <input type="checkbox"/> <input type="radio"/> change in mood | <input type="checkbox"/> <input type="radio"/> accelerated heart rate |
| <input type="checkbox"/> <input type="radio"/> irritability | <input type="checkbox"/> <input type="radio"/> shortness of breath |
| <input type="checkbox"/> <input type="radio"/> feelings of worthlessness | <input type="checkbox"/> <input type="radio"/> sweating |
| <input type="checkbox"/> <input type="radio"/> changes in sleeping patterns | <input type="checkbox"/> <input type="radio"/> chest pain |
| <input type="checkbox"/> <input type="radio"/> loss of energy | <input type="checkbox"/> <input type="radio"/> feelings of choking |
| <input type="checkbox"/> <input type="radio"/> loss of interest in activities | <input type="checkbox"/> <input type="radio"/> nausea |
| <input type="checkbox"/> <input type="radio"/> loss or decrease in sexual interest | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of death |
| <input type="checkbox"/> <input type="radio"/> increase of energy | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of wanting to commit suicide |
| <input type="checkbox"/> <input type="radio"/> difficulty concentrating | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of harming others |
| <input type="checkbox"/> <input type="radio"/> nightmares | <input type="checkbox"/> <input type="radio"/> cutting or burning myself |
| <input type="checkbox"/> <input type="radio"/> substance abuse (alcohol or drugs) | <input type="checkbox"/> <input type="radio"/> seeing things that others do not |
| <input type="checkbox"/> <input type="radio"/> problems with attention, motivation, memory | <input type="checkbox"/> <input type="radio"/> hearing voices that others do not |
| <input type="checkbox"/> <input type="radio"/> recurrent and excessive anxiety or worry | <input type="checkbox"/> <input type="radio"/> paranoid thoughts |

DESCRIBE YOUR CURRENT FUNCTIONING:

Currently, I am able to...

	n/a	Never	Rarely	Sometimes	Frequently	Always
attend work/classes						
concentrate on duties /tasks/assignments						
maintain employment						
maintain satisfying relationship w/ significant other						
maintain satisfying relationships w/ family members						
initiate & maintain satisfying social relationships w/ peers						
take care of my self & participate in social/recreational activities						
decide on plans for future						
demonstrate adequate coping skills, esp under increased stress						
seek assistance when stress and problems are not manageable						
decrease substance abuse and/or other high-risk behaviors						

GPA (if applicable): Current? _____ Last Semester? _____ High School (optional)? _____

Are you thinking about leaving your job or school? No Yes

Are you at risk for being of being fired from your job or expelled from school? No Yes

Describe how this problem has affected your work and /or academic performance:

Describe struggles you are having in your relationships (friendships / dating / partner)?

Describe your support systems (friends, family, spiritual or cultural groups, etc.): Are they in Boulder? No Yes

Describe your past and current levels of exercise or physical activity:

PERTINENT PERSONAL/FAMILY HISTORY: (Please fill in information about yourself and your family members)

	<i>Biological?</i>	<i>Age</i>	<i>Occupation</i>	<i>Mental Health Concerns</i>	<i>Physical Health Concerns</i>	<i>Medical Concerns</i>
<i>You</i>	n/a					
<i>Parent</i>	Y N					
<i>Parent</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Child M F</i>	Y N					
<i>Child M F</i>	Y N					
<i>Child M F</i>	Y N					
<i>Others</i>						

Are your parents married / separated / divorced / remarried?

If divorced, how old were you at that time?

Describe your relationship with each parent:

Describe your relationship(s) with your sibling(s):

Describe your relationship(s) with your child/children:

Have you lost any direct family members? No Yes – Please list:

Do family members (grandparents, aunts, uncles, etc.) have a history of mental illness (depression, anxiety, etc.)? No Yes – Please list:

Is there a history of alcoholism in your extended family? No Yes – Please list:

MEDICAL HISTORY

<i>Have you had...</i>	<u><i>Recently (if yes, describe)</i></u>	<u><i>Past (if yes, describe)</i></u>
a head injury?	N Y	N Y
a seizure?	N Y	N Y
loss of consciousness?	N Y	N Y
significant injuries or illness?	N Y	N Y
medications prescribed?	N Y	N Y
known allergies to medications?	N Y	N Y
hospitalization for a medical condition?	N Y	N Y

Please list current medications: _____

PREVIOUS MENTAL HEALTH TREATMENT

Age	With Whom	How Long	Focus of Treatment	Helpful?	List Medications
				N Y	
				N Y	
				N Y	

Have you ever been hospitalized for mental health treatment? No Yes If yes, was it voluntary? No Yes

SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

<i>Have you ever had...</i>	<u>Current</u> (if yes, describe)	<u>Past</u> (if yes, describe)
thoughts of hurting yourself?	N Y	N Y
thoughts of suicide?	N Y	N Y
a plan for suicide?	N Y	N Y
an attempted suicide?	N Y	N Y
thoughts of hurting someone else?	N Y	N Y
an incident of actually hurting someone else?	N Y	N Y

TRAUMA HISTORY

Have you ever been a victim of a crime? No Yes

Physical (e.g., car accidents, assault, abuse, head trauma)

Emotional (e.g., victim of crime, abuse, loss or death of relative / friend)

Sexual (e.g., sexual harassment, sexual assault)

LEGAL HISTORY: Have you ever been arrested or convicted of a legal violation?

SEXUAL ACTIVITY: Are you sexually active? No Yes

Do you use latex condoms or other safer sex techniques every time to prevent sexually transmitted diseases? No Yes

SUBSTANCE USE HISTORY: Please indicate your use of the following substances:

List	Current Use		Past Use	
	Frequency # of days of the week	Amount Per Day	Frequency # of days of the week	Amount of Use Per Day
Alcohol	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

PLEASE DESCRIBE ANYTHING ELSE YOU WOULD LIKE TO TALK ABOUT:

PLEASE DESCRIBE YOUR GOALS FOR THERAPY: