Catholic Social Services Of the Upper Peninsula

ADULT INTAKE QUESTIONNAIRE

Date:_____ Date of birth: _____ Age: ____ Referred by:_____

Name:_____
Last First Middle Initial Maiden Name (If applicable)

Emergency Contact Person: _____ Phone: _____

Circle marital status: *Single* *Married* *Separated* *Divorced* *Widowed* *Living together*

Religion:_____Comments:_____

_____

Ethnic Group: Caucasian _____ Native American _____ Asian _____ African-American _____

Hispanic ____ Other ____ Are you a member of a tribe? Y or N If yes so, which one? _____

Why are you requesting counseling? Please write a brief statement explaining your difficulty.

_____

_____

_____

_____

I. MENTAL HEALTH CHECKLIST

Please answer the following questions as completely as possible. The following information will assist your therapist in helping you with your problems(s). Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins – "Have you ever ...."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

YES NO

Who and When:

_____

_____

_____

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?

YES NO

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?

YES NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?

YES NO

6. a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES NO

b) Did you ever attempt to kill yourself? YES NO

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?

YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

YES NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property?

YES NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?

YES NO

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?

YES NO

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?

YES NO

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

YES NO

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.

YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you had a special learning problem?

YES NO

II. MEDICAL

Do you have or have you had any of the following conditions? **P = Past** **C = Current**

__ Currently pregnant __months	__ Arthritis	__ Cancer_____
__ Past pregnancies	__ Cirrhosis	__ Anemia
__ Chronic Pain_____	__ Overweight	__ Diabetes/high blood sugar
__ Asthma	__ Underweight	__ Seizures
__ G.I. Problem_____	__ Memory problems	__ Head injury
__ Heart Disease	__ Liver Problems	__ Heart Attack/injury
__ High Blood Pressure	__ Kidney Problems	__ Heart murmur
__ Menstrual Problems	__ Low Blood Sugar	__ Emphysema or COPD
__ Rheumatic Fever	__ Meningitis	__ Migraines
__ Ulcers	__ Stroke	__ Thyroid illness _____
__ Chronic fatigue	__ Glaucoma	__ Cerebral Palsy
__ Hearing Problems	__ Vision Problems	__ Venereal Disease

__ Sleep problem _____: ***Hours and quality of sleep***_____

__TB __Hepatitis __HIV/AIDS virus

__ Low appetite __ Excessive appetite ***Average number of meals a day*** _____

Other illnesses _____

What is the date of your last FULL physical exam?: _____ Dr. _____

III. MEDICATIONS

1. Have you ever been prescribed **psychiatric** medications that you no longer take? Yes No

(If yes, please list and give reason for discontinuing) _____

_____

2. Drug Allergies? _____ Yes No

3. Are you taking **any medications** at this time? Yes No

IV. SURGERY AND HOSPITALIZATIONS

1. Have you ever had surgery? Yes No
   If yes, please list:

When (dates) Facility Reason for Surgery/What Procedure?

_____ _____ _____

_____ _____ _____

Medications and Supplements	Dose	Purpose	Prescribing Physician	Medication Taken as Prescribed?
1.				____ Yes ____ No
2.				____ Yes ____ No
3.				____ Yes ____ No
4.				____ Yes ____ No
5.				____ Yes ____ No
6.				____ Yes ____ No
7.				____ Yes ____ No
8.				____ Yes ____ No
9.				____ Yes ____ No
10.				____ Yes ____ No

_____ _____ _____

2. Have you ever been hospitalized for reasons other than surgery? Yes No
   If yes, please list:

When (dates) Hospital Reason for Hospitalization

_____ _____ _____

_____ _____ _____

_____ _____ _____

V. ALCOHOL AND OTHER DRUG USE HISTORY

1. To help us in understanding your situation, it is helpful if your counselors know about your use of alcohol and drugs. Your answers will be kept private.

	Check if Never Used	Age of first use	How used? (oral, IV, smoke, inhale)	Date of last use	Typical frequency of use	Typical amount used per day	Days Used in Last 30	Initially a Prescription? Y or N
Alcohol (Beer/Wine/Liquor) Type_____								
Sedative, tranquilizers (Xanax, Valium, Ativan, etc)								
Inhalants (glue, solvents, Sprays, gasoline)								
Cocaine/Crack								
Amphetamines/ Methamphetamines Other Speed								
Marijuana/Hash								
Heroin								
Other Opioids: morphine, oxycodone, Methadone, Suboxone, pain pills								
Hallucinogens/LSD/ Ecstasy								
PCP								

1. Have you injected any drugs in the past 10 years? Yes No
2. Have you ever gone to a support group such as Alcoholics Anonymous, SMART or Narcotics Anonymous because of an alcohol or other drug problem? Yes No
3. Have you ever had counseling or treatment for an alcohol or other drug problem? Yes No

When? Where?

_____ _____

_____ _____

_____ _____

4. Have you ever spent more time drinking or using drugs than you intended? Yes No
5. Have you ever neglected some of your usual responsibilities because of using alcohol or drugs? Yes No
6. Have you ever wanted to cut down on your drinking or drug use? Yes No
7. Have anyone ever objected to your drinking or drug use? Yes No
8. Have you ever been preoccupied with drinking or using drugs? That is, have you ever found yourself thinking a lot about drinking or using? Yes No
9. Have you ever used alcohol or drugs to ease emotional discomfort such as sadness, anger, or boredom? Yes No
10. Have you ever overdosed on alcohol or other drugs, where you were in danger? Yes No
11. Comments (what, when): _____
12. Do you use **nicotine** (smoke or chew)? Amount/type:_____ Yes No
13. Do you consume **caffeine** (coffee, tea, cola, etc.) on a regular basis? Yes No
14. If so, how much daily? _____

VII. COMPULSIVE BEHAVIORS

Please **circle** any of your behaviors that are a concern for you:

Shopping Shoplifting Lying Computer use Electronic gaming Hoarding items or pets

Risky or excessive sex Pornography Internet relationships Hair pulling Gambling

VIII. FAMILY OF ORIGIN:

Parent's Status	Mother	Father	Step-Mother	Step-Father	Other
Alive (Present Age)					
Deceased (Age)					
Year of Death					
Cause					
Occupation					

1. Who raised you? _____
2. How old were you when you no longer lived with your family? _____
3. What was your reason for leaving? _____
4. How many brothers/sisters do you have? 0 1 2 3 4 5 6 7 More _____
5. What is your current relationship with your sisters/brothers? ____Good ____Fair ___Poor
6. Who in your family do you feel closest to? _____In what way?_____
7. Is there anything from your childhood that you feel is related to your current difficulties? Yes No

   Please describe:_____
8. Does your family have a history of medical problems? Yes No

   (If yes, describe) _____
9. Does your family have a history of substance abuse? Yes No

   (If yes, describe) _____
10. Does your family have a history of mental health problems? Yes No

    (If yes, describe) _____
11. Has anyone in your family committed suicide? Yes No

    (If yes, describe) _____

IX. RELATIONSHIP HISTORY INCLUDING HISTORY OF CHILDREN

1. If married or in a relationship for how long? _____

Household Members Including children	Relationship & Quality of Relationship	Age	Education

Household Members Including children	Relationship & Quality of Relationship	Age	Education

For additional members, note names, relationship, ages:

_____

_____

2. How well do you get along with other people? _____ Good _____ Fair _____ Poor

3. Have your relationships with people changed recently? Yes No

(If yes, how?) _____

4. Are you distressed about your current relationships? Yes No

Comments: _____

_____

5. If intimate relationships have ended, what were the reasons? _____

_____

_____

XI. EDUCATION HISTORY

1. What was the highest grade or degree you completed? _____

2. If you did not complete high school, why not? _____

3. Were you ever in special education? Yes No

(If yes, describe) _____

4. Did you ever have difficulties in school? Yes No

(If yes, describe the type of difficulty) _____

5. Do you have any current educational goals? Yes No

(If yes, describe) _____

XII. CAREER/WORK HISTORY

1. Who is your current employer or volunteer work place? _____

2. What type of work do you do? _____ Length of Service: _____

3. Are you unsatisfied with your work? Yes No

4. Prior jobs/employment: _____

XIII. MILITARY HISTORY – Yes _____ No _____

1. Military History: Branch: _____ Length of Service: _____ Type of Discharge: _____

2. Service in combat zone or any service related trauma? Yes No

(If yes, where and when) _____

_____

XIV. LEGAL HISTORY

1. Have you been involved with: (Circle all that apply) Probation Parole Probate Court None

If so, describe what offense/where: _____

2. If you've ever been in jail or prison, please list where, dates, reason:_____

_____

3. Current Probation/Parole Officer (*if applicable*): _____

4. Are the services you are currently seeking court ordered? Yes No

(If yes, by whom:) _____

XV. SITUATIONS THAT MIGHT AFFECT TREATMENT

1. Are you experiencing financial difficulty? Yes No
(If yes, please explain) _____

2. Do you need special accommodations? Yes No
(If yes, please check all that apply.)

Foreign Language Interpreter: _____ Transportation: _____

Sign Language Interpreter: _____ Child Care: _____

Scheduling Accommodations: _____

XVI. ADDITIONAL INFORMATION

1. What do you like to do for **fun**? _____

_____

2. Other important information you would like us to know: _____

_____

_____

Client Signature: _____ Date:_____

THANK YOU! PLEASE FEEL FREE TO TALK WITH YOUR THERAPIST ABOUT ANY PART OF THIS FORM!

Clinician Signature:_____ Date reviewed with client:_____