Name ______________________________ Date ____________

CLIENT INTAKE QUESTIONNAIRE

GENERAL INFORMATION

Name: ______________________ Date of Birth: ____________________
Social Security Number: ______________________________
Street Address: ______________________________
City, State, Zip ______________________________
Home Phone: ____________________ May I contact you at home?: [ ]Yes [ ]No
Work Phone: ____________________ May I contact you at work?: [ ]Yes [ ]No
Cell Phone: ____________________ May I contact you on your cell?: [ ]Yes [ ]No
Marital Status: [ ]Single [ ]Cohabitating with S.O. [ ]Married [ ]Divorced [ ]Widowed
Children?: [ ]Yes [ ]No If yes, custody status: ____________________
Educational Level: [ ]Less than high school [ ]High school graduate [ ]Some college [ ]College graduate [ ]Graduate school+
Occupation: ____________________ Years at current job: ____________________
Current Employer: ______________________________
Work Address: ______________________________

Emergency Contact: ____________________ Relationship to you: ____________________
Emergency Contact's phone number: ______________________________

FINANCIAL INFORMATION

Annual Household Income: ____________________
Living Arrangements: [ ]Supported by Family [ ]Own [ ]Rent
How do you plan to pay for treatment? [ ]Cash [ ]Check [ ]Insurance

Primary Insurance Information:

Name of Employer: ______________________________
Name of Policy Holder: ______________________________
Name of Insurance: ______________________________
Address of Insurance Company: ______________________________
Insurance Company Telephone #: ______________________________
Policy #: ____________________ Group #: ____________________
Deductible Amount: $ ____________________ Amount met this year: $ ____________________

Secondary Insurance Information:

Name of Employer: ______________________________
Name of Policy Holder: ______________________________
Name of Insurance: ______________________________
Address of Insurance Company: ______________________________
Insurance Company Telephone #: ______________________________
Policy #: ____________________ Group #: ____________________
Deductible Amount: $ ____________________ Amount met this year: $ ____________________

I authorize Ellen V. Garbuny, LSW. to release any medical information regarding the medical, mental health or alcohol/drug abuse history, treatment, or benefits payable, including disability or employment-related information to any insurance company, the Plan Administrator, or their authorized agents that I have coverage with, for the purpose of validating and determining benefits payable for my treatment. This includes any information/reports that may be required by any managed care contracts associated with my insurance coverage. In signing this statement, I am aware that confidentiality regarding information given to managed care/insurance companies is relinquished. My confidentiality in this regard is protected only by the laws and ethics governing the managed care and insurance companies.

____________________ ______________________________
Date Client Signature (Parent if a client is a minor)

I also authorize payment of medical benefits to provider of services rendered Ellen V. Garbuny, LSW. This applies for any services rendered that I have not paid for at time of service. I also request payment of government benefits either to myself or to the party rendering the services who accepts the assignment.

____________________ ______________________________
Date Client Signature (Parent if client is a minor)

Name ____ Date __________________

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

What brings you into therapy today? ____

____

When did the problem arise? ____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) ____________	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] No [ ] Yes **Prior suicide attempts?**
If yes, when? ____.
Circumstances that led to the attempt: ____

____

[ ] No [ ] Yes **Current suicidal thoughts?**
If yes, describe: ____

____

[ ] No [ ] Yes **Prior outpatient psychotherapy?**
If yes, on _______occasions. Longest treatment by __________________ (Provider Name) for ____ sessions from _____/____ (Month/Year) to ______/________ (Month/Year)

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
__________	__________	______	__________	__________	__________	__________
__________	__________	______	__________	__________	__________	__________

[ ] No [ ] Yes **Has any family member had outpatient psychotherapy?** If yes, who/why (list all):____

____

[ ] No [ ] Yes **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
If yes, on _______occasions. Longest treatment at ______________________________ (Name of facility) from _____/_____ (Month/Year) to ______/______ (Month/Year)

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
__________	__________	______	__________	__________	__________	__________
__________	__________	______	__________	__________	__________	__________

Name ____ Date __________________

[ ] No [ ] Yes **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?** If yes, who/why (list all):____

[ ] No [ ] Yes **Prior or current psychotropic medication usage?** If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?
______	____	_____	_____	____	________	______	________
______	____	_____	_____	____	________	______	________

[ ] No [ ] Yes **Has any family member used psychotropic medications?** If yes, who/what/why (list all):____________________
____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

____

Parents' current marital status:

[ ] married to each other
[ ] separated for ____ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ____

Describe parents:

	Father	**Mother**
full name	______________	______________
occupation	______________	______________
education	______________	______________
general health	______________	______________

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: ___________ **Circumstances:** ______________________________
____
____

Special circumstances in childhood:______________________________
____
____

IMMEDIATE FAMILY

Marital status:

[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ___ years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:

[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
________	___	___	________
________	___	___	________
________	___	___	________

List children <u>not</u> living in same household as patient:

Name	Age	Sex	Relationship to patient
________	___	___	________
________	___	___	________
________	___	___	________

Frequency of visitation of above: ________________

Describe any past or current significant issues in <u>intimate</u> relationships: ____________________
____
____

Describe any past or current significant issues in other <u>immediate family</u> relationships: ____________________
____
____

Name ______________________________ Date ____________

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

____

List name of primary care physician:

Name ______________ Phone ____________

List name of psychiatrist: (if any):

Name ______________ Phone ____________

List any medications currently being taken (give dosage & reason):

____

____

____

List any known allergies: ______________________

List any abnormal lab test results:

Date ________ Result ______________

Date ________ Result ______________

Is there a history of any of the following in the family:

[ ] tuberculosis [ ] heart disease
[ ] birth defects [ ] high blood pressure
[ ] emotional problems [ ] alcoholism
[ ] behavior problems [ ] drug abuse
[ ] thyroid problems [ ] diabetes
[ ] cancer [ ] Alzheimer's disease/dementia
[ ] mental retardation [ ] stroke
[ ] other chronic or serious health problems ____________

____

Describe any serious hospitalization or accidents:

Date ______ Age ____ Reason ______________

Date ______ Age ____ Reason ______________

Date: ______ Age ____ Reason ______________

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other ____________

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Treatment history:

[ ] outpatient (age[s]__________)
[ ] inpatient (age[s]__________)
[ ] 12-step program (age[s]________)
[ ] stopped on own (age[s]________)
[ ] other (age[s]____________
describe:______________

Substances used: (complete all that apply)	**First use age**	**Last use age**	**Current Use (Yes/No)**	**Frequency**	**Amount**
[ ] alcohol	______	______	____	_____	____
[ ] amphetamines/speed	______	______	____	_____	____
[ ] barbiturates/owners	______	______	____	_____	____
[ ] caffeine	______	______	____	_____	____
[ ] cocaine	______	______	____	_____	____
[ ] crack cocaine	______	______	____	_____	____
[ ] hallucinogens (e.g., LSD)	______	______	____	_____	____
[ ] inhalants (e.g., glue, gas)	______	______	____	_____	____
[ ] marijuana or hashish	______	______	____	_____	____
[ ] nicotine/cigarettes	______	______	____	_____	____
[ ] PCP	______	______	____	_____	____
[ ] prescription________	______	______	____	_____	____
[ ] other__________	______	______	____	_____	____

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other ______________________________

Name ____ Date _________________

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: _________________

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Military history:
[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident
____

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison _________ time(s)
total time served: _______
describe last legal difficulty: ______
____

Sexual history:
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _______
[ ] age first pregnancy/fatherhood ___
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age __ to ___
Additional information: ____________________________________

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): ______________________
____
describe any cultural issues that contribute to current problem: _______
____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _____________________
____
____