WELLSPRINGS FAMILY COUNSELING CENTER

Patient Intake Questionnaire

Date:_____

Name (Last, Middle Initial, First): _____

Street Address: _____ City: _____ State: _____

Home phone: _____ Alternate phone: _____

E-mail: _____ Alternate E-mail: _____

Please indicate the means by you prefer to be contacted. You may check more than one:

Phone: _____ Text: ____ E-mail: _____

Date of Birth: _____ Age: _____

Gender:

_____

Sexual Orientation:

_____

What type of services are you currently seeking? Please mark an "X" by the type of services you are seeking.

___Individual therapy
___Marital/Couples therapy
___Family therapy
___Unsure

Goals of Treatment:

What compelled you to seek therapy at this time?

_____
_____
_____

Describe any current concerns, issues, or problems:

_____
_____
_____
_____

What do you hope to gain from therapy?

_____
_____
_____
_____

Relationship Status (Please check all that apply):

Are you presently married or involved in a relationship? Yes_____ No_____
If you answered yes, how would you describe your current level of satisfaction with the relationship?

_____
Have you married previously? If yes, when? _____
Name of the individual whom you identify as your significant other:

_____

If you are married, or in a relationship, rate your level of contentment/happiness/satisfaction in the relationship on a scale of 1 to 10 (Number 1 indicates a sense of being very or extremely happy and the number 10 indicates a sense of being extremely unhappy). Briefly explain the rating you give in the space provided:

_____
_____
_____
_____

Source of Income:
Employment: _____ Unemployment: _____ Spouse/Significant Other: _____
Social Security: _____ Short Term-Disability: _____
Other: _____

Current Employment Status (Please check all that apply):
Working Full-Time: _____ Working Part-Time: _____ Retired: _____
On medical leave: _____Unemployed and looking for work: _____
Not employed due to other reasons ____Full-Time Student: _____
Part-Time Student: _____

Education Information: (Please check the *highest* level of education/degree you have received):
Elementary, Grades 1-8: _____ Some High School (no diploma): _____
High School Diploma/GED: _____Some College (no degree): _____ Technical/Trade School Graduate: _____Associate's Degree: _____ Bachelor's Degree: _____ Master's Degree: _____
Professional Graduate Degree (i.e., MD, JD, etc.):_____ Doctoral Degree (i.e., PhD, EdD, etc.):_____

Military History:

Currently on active duty: _____ Served in Military (please circle length of time served) for: _____ number of weeks, months, or years. Never served in the military: _____
If you have served in the military were you ever deployed, yes or no? Yes: _____ No: ____. If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

_____
_____
_____
_____

Legal History:
Have you been ordered by the court to participate in this therapy, yes or no? Yes: ____ No: ____If yes, you may be required to supply supporting documentation such as a copy of the court order.

Are you currently involved in any kind of litigation or legal dispute, yes or no? Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

Do you anticipate being involved in litigation or legal dispute, yes or no? Yes: _____ No: ____ If yes, please explain:

_____
_____
_____

Emergency Contact Information: (Who you prefer me to contact in case of an emergency)
Name: _____ Relationship: _____
Phone number: _____ Email: _____

Referral Information:
Were you referred? Yes: _____ No: _____ I f referred, by whom?
_____

Payment Information:
Please indicate how you intend to pay for treatment:
Cash: ___ Check: ___ Credit Card: ____ Employee Assistance Program: ____Insurance: _____
Third-Party: _____. If a third-party will be paying for your treatment please provide the following information: Name of the person paying for your therapy: _____
Your Relationship to this person: _____
Contact Information for this person: _____

If you are planning to use health insurance, please provide the following information:
Name of Insurance Company: _____
Subscriber's Name: _____
Insured's ID number: _____ Group Policy Number: _____

Co-Payment Amount: _____
Insurance Claim's Mailing Address: _____
Telephone number: _____

Previous Mental Health Treatment History:
Have you participated in therapy? Yes: _____ No: ____ If YES, please complete the information below:

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of treatment: _____
Focus of treatment: _____

Name: _____Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Email: _____
Street Address: _____City: _____ State: _____
Dates of treatment: _____
Focus of treatment: _____

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of treatment: _____
Focus of treatment: _____

Have you ever been hospitalized because of a mental health disorder, yes or no? Yes: _____ No: _____. If you indicated that you have been hospitalized for a mental health disorder, please complete the following information:

Reason for hospitalization:
_____
Was hospitalization voluntary or involuntary? Please check: Voluntary: _____ OR Involuntary: _____
How long was your hospitalization?
_____
Where were you hospitalized?
_____
_____
Course of treatment during hospitalization:
_____

_____
_____

Provide the name of the providers who treated you below. Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist).

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of treatment: _____

Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of treatment: _____

Name: _____Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of treatment: _____

Current Mental Health Treatment:
Are you currently participating in therapy or counseling? Yes: ____ No: _____ If YES, please complete the following information: _____

Name of Current Provider: _____
Type of provider: _____
Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of Treatment: _____
Focus of Treatment: _____

Name of Current Provider: _____
Type of Provider: _____
Phone Number: _____Email: _____
Street Address: _____ City: _____ State: _____
Dates of Treatment: _____
Focus of Treatment: _____

If you are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. You may be required to sign and *"Authorization for Release of Confidential*

Information" form which will be provided to you and maintained as part of your clinical record long with a copy of this patient intake form.***** Please Initial: _____

If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s), yes or no? Yes _____ No_____. If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below.

For example: *"Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)."*

_____
_____
_____
_____
_____
_____
_____
_____

If you are currently under the care of a psychologist, have you participated in any psychological assessments or tests yes, or no? Yes ____ No _____. If you have participated in psychological testing, please list the type of test performed, the specific name of the test, and the date(s) the test(s) were administered.

For example: *"Personality Test (Type), Minnesota Multiphasic Personality Inventory "MMPI-2" (Specific name of test), February 01, 2017 (Date test was administered)."*

_____
_____
_____
_____
_____
_____
_____
_____

***California Civil Code Section, 56.10 states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without the patient's consent. By initialing, you acknowledge and understand that I may contact either your current or former mental health care and/or medical providers only to discuss issues relevant to your diagnosis and treatment without your consent. Initial: _____**

Medical Treatment Information:
Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition, yes or no? Yes: _____ No: _____. If you currently have a medical condition, please provide the following information:

Current medical condition: _____
How long have you had the condition? _____
Is it a medically treatable condition, yes or no? Yes: _____ No: _____
If, it is not a medically treatable condition (i.e., palliative care), please describe:
_____
_____
_____
_____
If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side effects.

For example: *"High blood pressure medication (type of medication); 2 years (length of time on medication); Drowsiness (example of a side effect)*.
_____
_____
_____
_____
_____

Trauma History (Optional):
Have you been – or, are you currently being – emotionally, physically, or sexually abused? Yes _____ No _____ Prefer not to answer _____. If you checked "Yes," you may use the space below to describe the underlying circumstances:
_____
_____
_____
_____
_____

Family of Origin Information (Optional):
Were you adopted, yes or no? Yes: _____ No: _____. If you were adopted, at what age were you adopted? _____ .

If you were adopted, do you have a relationship with your birth mother and/or father, yes or no? Yes: _____ No: _____If yes, please describe the nature of the relationship. For example, explain how the relationship with your biological parent(s) was established, how old you were at the time the relationship began, the frequency of contact you had or currently have, and the nature of the relationship:

_____
_____
_____
_____
_____
_____

If you were adopted, what type of relationship do you/did you have with your adopted parents?

_____
_____
_____
_____
_____

If you were *not* adopted, what type of relationship do you/did you have with your biological parents?

_____
_____
_____
_____
_____

Are either of your parents (biological or adopted, and/or step parents) deceased? If your parents are deceased, please provided the following information:

- Mother/Stepmother has been deceased for _____ days/weeks/months/years. What was your age at the time of your mother's/stepmother's passing? _____
- Father/Stepfather has been deceased for _____ days/weeks/months/years years. What was your age at the time of your father's/stepfather's death? _____

Indicate the marital status of your parents (biological/adopted). Check all that may apply:

- Currently married to each other for _____ years
- Currently separated for _____ years
- Divorced for _____years
- Mother remarried _____ times
- Father remarried _____ times
- Mother currently single after being separated/divorced for _____ years
- Father currently single after being separated/divorced for _____ years
- Mother is currently involved with someone, yes or no? If yes, for how long?
  _____

- Father is currently involved with someone, yes or no? If yes, for how long? _____

Do you have any biological siblings, adopted siblings, step siblings, or half siblings, yes or no? Yes: ____ No: ____. If you have any siblings, how many? _____. In the space provided below, list the name and ages of each of your siblings and briefly describe the nature of your relationship as being "close," or "not close," or "estranged," or any other word that describes the nature and extent of your relationship with your siblings.

_____
_____
_____
_____
_____
_____
_____
_____

Which of the following statements most resonates with you:

- My parents were present during my *entire* childhood, yes or no? Yes: _____No: _____. Explain:_____
  _____
  _____
  _____
- My parents were present during a *part* of my childhood, yes or no? Yes: ____ No: _____. Explain:_____
  _____
  _____
  _____
- My parents were *not present* at all during my childhood, yes or no? Yes: ____ No: ____. Explain:
  _____
  _____
  _____
  _____

Which of the following describes your childhood family experience:

- _____ It was an outstanding home environment
- _____ It was a normal home environment
- _____ It was a chaotic home environment
- _____ Prefer not to answer

If you indicated that your home environment was chaotic, please explain. For example, you may have witnessed physical/verbal/sexual abuse towards others, or you may have experienced physical/verbal/sexual abuse from others:

_____
_____
_____
_____
_____
_____

Mental Health/Risk Assessment:
Please identify if you have experienced any of the following and whether this is a past, current, or reoccurring issue:

- _____ Suicidal Thoughts.
  - Past:_____ Present: _____ Reoccurring: _____
- _____Thoughts of wanting to intentionally harm myself.
  - Past:_____ Present: _____ Reoccurring: _____
- _____ Thoughts of wanting to intentionally cause harm to someone else.
  - Past:_____ Present: _____ Reoccurring: _____
- _____ Post-Traumatic Stress.
  - Past:_____ Present: _____ Reoccurring: _____

If you are currently experiencing any thoughts of either harming yourself or someone else please answer the following questions:

How long have you had these thoughts?

_____

How frequently do you have these thoughts?

_____
_____
_____

Do you have a plan and/or the means to carry out either the threat of harm to yourself or to someone else, yes or no? Yes: _____ No: _____If yes, please explain:

_____
_____
_____

Have you ever tried to harm yourself or anyone else in the past, yes or no? Yes: ____ No: ____If yes, please explain:

_____
_____

_____

Is there anything that would stop, or prevent, you from harming yourself or someone else, yes or no? Yes: ____ No: ____ If yes, please explain?

_____
_____
_____

If you indicated that there is not anything that would prevent you from harming yourself or someone else, please identify how likely it is that you might actually harm yourself or someone else:

Imminently likely: _____ OR Not at all likely: _____

Alcohol/Substance Use History (Optional):
Family Alcohol Abuse History: To the best of your knowledge, please indicate which of the following family member(s) struggles or struggled with alcohol/substance abuse or addiction:

Father: ___ Mother: ____ Grandparent(s): ____ Sibling(s): _____ Stepparent(s): _____
Uncle(s)/Aunt(s):____ Spouse/Significant Other: _____ Children: _____

Please indicate your substance use status:

No history of use: _____ Actively using alcohol or drugs: ____ In early full remission: ____
In early partial remission: _____In sustained full remission: _____
In sustained partial remission: _____

If you indicated that you have an alcohol/substance abuse or addiction history, please identify the types of treatment you have participated in, or are currently participating in, and how long you have been participating in the particular treatment.

Outpatient treatment:
_____
Inpatient treatment:
_____
12-Step Program:
_____
Stopped using on my own:
_____
Other Method:
_____

Was the above treatment method effective? Please explain:
_____

_____

Please identify the type(s) of substances you are using, how frequently you use the substance, and how long you have been using the substance, and your frequency of use (i.e., daily, as needed, no regulation of use, etc.)

Opioid(s): ____ Classification: ____ Length of use: _____ Frequency of use: _____

Heroin: ____ Length of use: _____ Frequency of use: _____

Cigarettes/Tobacco: ___ Length of use: _____ Frequency of use: _____

Alcohol: ____ Length of use: _____ Frequency of use: _____

Amphetamines: ____ Length of use: _____Frequency of use: _____

Barbiturates: ____Length of use: _____ Frequency of use: _____

Cocaine: ___ Length of use: _____ Frequency of use: _____

Crack: _____ Length of use: ___ Frequency of use: _____

Hallucinogens: _____ Length of use: ____ Frequency of use: _____

Inhalants: _____ Length of use: ____Frequency of use: _____

Marijuana: _____ Length of use: ____ Frequency of use: _____

Other: _____ Length of use: ____ Frequency of use: _____

If you have indicated that you have used, or are currently using substances, please indicate what side effects and or consequences you experienced or are experiencing as a result of the use.

Overdose: _____ Suicidal Impulse: _____ Depression: _____ Anxiety: _____
Blackouts: _____ Loss of control: _____ Medical conditions: _____Other: _____
Please use the space provided to describe any other effects or consequences you have experienced:

_____
_____
_____

Spiritual/Cultural History (Optional):
Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

_____
_____
_____

Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? If so, please describe:

_____
_____
_____

Additional Information

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

Patient Signature: _____ Date: _____