

Confidential Client Intake Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Relationship to Client: _____

What are your interests and hobbies?

Do you have any cultural, spiritual or religious practices that are important to you?

How is your physical health? (illness, chronic pain, exercise)?

Medications? _____

Are you seeking assistance from other medical or mental health professionals?

Who referred you to therapy?

What is the crisis or concern that brings you to therapy?

Who is the person or issue you are most concerned about?

Possible Problems

Listed below are possible problems you and your family might be having. Please rate each by your degree of concern by circling the issue and the number that relates to the intensity. Please explain your level of concern.

1. **Suicide Potential or Depression?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

2. **Alcohol or Drug Abuse?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

3. **Family or Relationship Conflict?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

4. **Worry or Anxiety?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

5. **Verbally Abusive Behavior?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

6. **Sexually Abusive Behavior or Sexual Assault?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

7. **Physically Abusive Behavior?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

8. **Other Problem Behaviors?** (low) 1 2 3 4 5 6 7 8 9 10 (high)

Why? _____

Assessment

Why do you think there are problems for you or your family?

Problem Solving

What is the main goal or need you have for the first session?

What are your ideas on how that goal can be accomplished?

Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name _____ Age _____ Sex: Female Male Today's Date _____

1. During the last 4 weeks, how much have you been bothered by any of the following problems:

| | Not bothered | Bothered a little | Bothered a lot |
|---------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| a. Stomach pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Back pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pain in your arms, legs or joints (knees, hips, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Menstrual cramps or other problems with you period... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Pain or problems during sexual intercourse..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Headaches..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Chest pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Dizziness..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Fainting spells..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Feeling your heart pound or race..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Shortness of breath..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Constipation, loose bowels, or diarrhea..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Nausea, gas, or indigestion..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|
| a. Little interest or pleasure doing things..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Feeling down, depressed, or hopeless..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Trouble falling or staying asleep, or sleeping too much. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Feeling tired or having little energy..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Poor appetite or overeating..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Trouble concentrating on things, such as reading the newspaper or watching television..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Thoughts that you would be better off dead or of hurting yourself in some way..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- 3. Questions about anxiety** **NO** **YES**
- a. In the last 4 weeks, have you had an anxiety attack - suddenly feeling fear or panic?.....

If you checked "NO", go to question #5

- b. Has this ever happened before?
- c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?.....
- d. Do these attacks bother you a lot or are you worried about having another attack?.....

4. Think about your last bad anxiety attack. **NO** **YES**

- a. Were you short of breath?
- b. Did your heart race, pound, or skip?
- c. Did you have chest pain or pressure?
- d. Did you sweat?
- e. Did you feel as if you were choking?
- f. Did you have hot flashes or chills?
- g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?.....
- h. Did you feel dizzy, unsteady, or faint?
- i. Did you have tingling or numbness in parts of your body?
- j. Did you tremble or shake?
- k. Were you afraid you were dying?

5. Over the last 4 weeks, how often have you been bothered by any of the following problems: **Not a all** **Several days** **More than half the days**

- a. Feeling nervous, anxious, on edge, or worrying a lot about different things.....

If you checked "Not at all, go to questions #6

- b. Feeling restless so that it's hard to sit still.....
- c. Getting tired very easily.....
- d. Muscle tension, aches, or soreness.....
- e. Trouble falling asleep or staying asleep.....
- f. Trouble concentrating on things, such as reading a book or watching TV.....
- g. Becoming easily annoyed or irritable.....

- 6. Questions about eating** **NO** **YES**
- a. Do you often feel that you can't control what or how much you eat?.....
- b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?.....

If you checked "NO" to either "a" or "b", go to question #9

- c. Has this been as often, on average, as twice a week for the last 3 months?.....

- 7. In the last 3 months have you often done any of the following in order to avoid gaining weight?** **NO** **YES**
- a. Made yourself vomit?
- b. Took more than twice the recommended dose of laxatives?
- c. Fasted – not eaten anything at all for at least 24 hours?
- d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?.....

- 8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?** **NO** **YES**
-

- 9. Do you ever drink alcohol (including beer or wine)?**

If you checked "NO" go to question #11

- 10. Have any of the following happened to you more Than once in the last 6 months?** **NO** **YES**
- a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.....
- b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.....
- c. You missed or were late for work, school, or other activities because you were drinking or hung over.....
- d. You had a problem getting along with other people while you were drinking.....
- e. You drove a car after having several drinks or after drinking too much.....

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- | | | | |
|---------------------------------|-------------------------------|---------------------------|--------------------------------|
| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Nine Symptom Checklist

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Read each item carefully, and circle your response.

- a. Little interest or pleasure in doing things

Not at all Several days More than half the days Nearly every day

- b. Feeling down, depressed, or hopeless

Not at all Several days More than half the days Nearly every day

- c. Trouble falling asleep, staying asleep, or sleeping too much

Not at all Several days More than half the days Nearly every day

- d. Feeling tired or having little energy

Not at all Several days More than half the days Nearly every day

- e. Poor appetite or overeating

Not at all Several days More than half the days Nearly every day

- f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

Not at all Several days More than half the days Nearly every day

- g. Trouble concentrating on things such as reading the newspaper or watching television

Not at all Several days More than half the days Nearly every day

- h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

Not at all Several days More than half the days Nearly every day

- i. Thinking that you would be better off dead or that you want to hurt yourself in some way

Not at all Several days More than half the days Nearly every day

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. Have you felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Score: __ /4

2/4 or greater = positive CAGE, further evaluation is indicated

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

| | Not True | Somewhat True | Certainly True |
|----------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Considerate of other people's feelings..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restless, overactive, cannot stay still for long..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often complains of headaches, stomach-aches or sickness... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shares readily with other youth (i.e. books, games, food)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often loses temper..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Would rather be alone than with other youth..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Generally well behaved; usually does what adults request..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Many worries or often seems worried..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Helpful if someone is hurt, upset or feeling ill..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Constantly fidgeting or squirming..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has at least one good friend..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often fights with other youth or bullies them..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often unhappy, depressed or tearful..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Generally liked by other youth..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily distracted, concentration wanders..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous in situations, easily loses confidence..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kind to younger children..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often lies or cheats..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Picked on or bullied by other youth..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Often offers to help others (parents, teachers, children)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thinks things out before acting..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Steals from home, school or elsewhere..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gets along better with adults than with other youth..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Many fears; easily scared..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Good attention span; sees work through to the end..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Signature _____

Date _____

Parent / Teacher / Other (Please specify):