Innervisions Counseling & Consulting Center S.C.

840 State Road 136, Suite #1, Baraboo WI 53913

231 East State Street, Mauston WI 53948

Phone: 608.477.9858 Fax: 877.560.0578

INTAKE QUESTIONNAIRE – ADULT

*Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.*

| IDENTIFYING INFORMATION *(for individual receiving services)* |
| --- |
| Name: |       |  | Date of Birth: |       |
| Street Address: |       |  | Sex: |       |
| City/State/Zip: |       |  | Marital Status: |       |
| Home Phone: |       |  | Cell Phone: |       |
| SSN: |       |  | Household Income: |       |
|  |  |  | Preferred Pronouns: | [ ] He/His/Him[ ] She/Hers/Her |
| Who referred you to Innervisions? |       |
|  |  |

| RACE: |
| --- |
| [ ]  White/Caucasian[ ]  American Indian or Alaska Native[ ]  Native Hawaiian or Pacific Islander[ ]  Unknown | [ ]  Asian[ ]  Black/African American[ ]  Two or more races |

| ETHNICITY: |
| --- |
| [ ]  Hispanic or Latino[ ]  Non-Hispanic or Non-Latino |  |

| LANGUAGE OF CHOICE: |
| --- |
| [ ]  English[ ]  Hmong[ ]  Russian[ ]  Laotian | [ ]  Spanish[ ]  German[ ]  French[ ]  Other:       |

| RELIGIOUS AFFILIATION: |
| --- |
| [ ]  Catholic[ ]  Muslim[ ]  Jewish[ ]  Amish[ ]  Mennonite | [ ]  Protestant *(including Lutheran, Methodist, etc.)*[ ]  Non-Denominational[ ]  No Affiliation[ ]  Other:       |

| DISABILITY: |
| --- |
| Do you have a disability? [ ]  No [ ]  Yes* If yes, please specify:
 |
| If you have a disability, does the office accommodate your needs? [ ]  No [ ]  Yes |
| * If no, please explain:
 |
| If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below: |
| *
 |

| PRESENTING PROBLEM *(current situation and history)*: |
| --- |
| What is the primary problem for which you are seeking help? |
| [ ]  Marriage or relationship[ ]  Family problems[ ]  Depression[ ]  Mood Swings[ ]  Behavior[ ]  Self-confidence | [ ]  Problems with children[ ]  Peer problems[ ]  Eating disorder[ ]  Alcohol/drug use[ ]  Physical problems[ ]  Work related | [ ]  Grieving[ ]  Abuse or trauma[ ]  Sexual functioning[ ]  Anger[ ]  Anxiety or worry[ ]  Other *(explain below)*: |
| *
 |
| How long have you had this/these problems *(indicate below)*? |
| *
 |
| Have you received treatment for this problem or any other problem in the past? | [ ]  No [ ]  Yes |
| * If yes, when, where and with whom?
 |

| SUICIDE RISK: |
| --- |
| Suicide Risk: | [ ]  Denies | [ ]  Ideation | [ ]  Intent | [ ]  Plan | [ ]  Attempt |
| Notes: |       |
| Danger to Others: | [ ]  Denies | [ ]  Ideation | [ ]  Intent | [ ]  Plan | [ ]  Attempt |
| Notes: |       |
| Past History of Suicide Risk: |       |
| Current/Recent Suicide Risk: |       |

| FAMILY HISTORY: |
| --- |
| Were drugs or alcohol a problem in your family when you were growing up? | [ ]  No [ ]  Yes |
| * If yes, please explain:
 |
| Do you or another family member have a history of alcohol or drug problem? | [ ]  No [ ]  Yes |
| * If yes, please explain:
 |
| Please describe your current alcohol consumption:       |
| Was there any type of abuse *(physical, sexual, domestic or emotional)* in your family or home? | [ ]  No [ ]  Yes |
| * If yes, please describe the circumstances:
 |
| Have you or any other family member experienced any type of abuse? | [ ]  No [ ]  Yes |
| * If yes, please explain:
 |

| LEGAL HISTORY: |
| --- |
| Please describe any involvement you have had with the legal system *(arrests, convictions, probation and parole)*:       |

| CURRENT FAMILY INFORMATION: |
| --- |
| Please provide the following information: |
|  | **Name (First and Last)** | **Date of Birth** | **Lives with you?** |
| Spouse/Significant Other: |       |       | [ ]  No [ ]  Yes |
| Child: |       |       | [ ]  No [ ]  Yes |
| Child: |       |       | [ ]  No [ ]  Yes |
| Child: |       |       | [ ]  No [ ]  Yes |
| Child: |       |       | [ ]  No [ ]  Yes |
| Child: |       |       | [ ]  No [ ]  Yes |
| Other (specify):       |       |       | [ ]  No [ ]  Yes |
| Other (specify):       |       |       | [ ]  No [ ]  Yes |
| Highest educational level achieved: |       |
| Military service: | [ ]  No [ ]  Yes |
| Occupation: |       |
| Current employer: |       |

| MEDICAL HISTORY: |
| --- |
| Primary Care physician/pediatrician: |       |
| Would you like Innervisions to coordinate care with your PCP? | [ ]  No [ ]  Yes - *(if yes, you will need to fill out a release of information for your PCP)* |
| Please check the appropriate box *(below)* if you have experienced any of these problems: |
| [ ]  Eye disease, injury, poor vision[ ]  Ear disease, injury, poor hearing[ ]  Nose, sinus, mouth, throat problems[ ]  Head injury[ ]  Convulsions or seizures[ ]  Memory problems[ ]  Extreme tiredness or weakness[ ]  Thyroid disease or goiter[ ]  Skin disease[ ]  Heart disease[ ]  Back, arm, leg or joint problems[ ]  Blood disease[ ]  Stomach problems[ ]  Premenstrual Syndrome (PMS)[ ] Eating disorder[ ]  Liver, gallbladder disease[ ]  Chest pain or angina pectoris | [ ]  Cancer[ ]  Bowel problems[ ]  Hemorrhoids, rectal bleeding[ ]  Loss of consciousness[ ]  Frequent or severe headaches[ ] Sleep disturbances[ ]  Neck stiffness, pain, swelling[ ]  Marked weight changes[ ]  Circulatory problems[ ]  Allergies or asthma[ ]  Diabetes[ ]  Encephalitis[ ]  Meningitis[ ]  Pregnancy no carried to term/stillbirths[ ]  High blood pressure[ ] Other:       |
| Please explain anything checked above:       |
| Please provide information about medication(s), prescription or over the counter, which you take regularly: |
| Medication | Dosage/Frequency | Prescribing Physician | For what condition? |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |
| Please list significant hospitalizations, operations, injuries (including broken bones):       |

| GOALS: |
| --- |
| What are your strengths?       |
| What are your weaknesses?       |
| What goals would you like to see reached as a result of your involvement with Innervisions Counseling?       |
| How will you know when these goals have been reached?       |

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| --- |
| **THERAPIST REVIEW:** |
| Signature: |  |  | Date: |  |
|  |  |  |  |  |