

Intake Questionnaire Assessment

** indicates a required field*

* What brings you to services at this time, what is your chief complaint? Is there something specific, such as a particular event? Be as detailed as you can.

How long has this been a problem for you? When did the symptoms or problem worsen? Please be specific.

* Have you received any past help for these problems? If so what kind and when? [i.e hospitalization, outpatient, IOP, PHP, residential, etc]

How do your current problems affect you? (in relation to work, school, family, relationships, personal well-being, etc...)?

How do you cope with stress?

Do you participate in any forms of gambling such as lottery tickets, scratch-offs, sports or race betting, bingo, or casino games? If so, please describe which activities you engage in, how often you participate, and the typical amount you spend.

Does any of your family member participate in any forms of gambling such as lottery tickets, scratch-offs, sports or race betting, bingo, or casino games? If so, please describe how you feel it impacts you.

*** What are your goals; what would you like to gain from services? Please be specific.**

*** Are you apart of the TrBHA, is so please provide your case management information [i.e email, phone number etc]. If you are not apart of the TrBHA please indicate NA:**

*** What are your needs in these areas:**

- ☐ Individual needs:
- ☐ Family needs:
- ☐ School needs:
- ☐ Culture needs:
- ☐ Community needs:

*** What are your strengths in these areas:**

- ☐ Individual strengths:
- ☐ Family strengths:
- ☐ School strengths:
- ☐ Culture strengths:
- ☐ Community strengths:

How would things be different if the difficulties were resolved?

How would you know things are getting better?

*** If this is a minor what is the legal/guardianship/ or custody status for this person, if this does not apply to you please indicate NA:**

*** What supports do you have in your life (family, friends, school, work, hobbies, etc...)?**

*** Preferred language:**

* Any military history?

* Have you seen a mental health professional before? If so, when and in what setting:

* Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Please note any previous psychiatric medication[s] prescribed. Please explain how each medications affected you.

* Who is your primary care physician? Please include type of MD, name and phone number.

* Any significant medical history? Please explain:

* Do you smoke, if yes can you indicate what and how often:, if no please just indicate no or NA:

* Do you have an advanced directive? If so what kind. If not, would you like to fill one out? [please notify your therapist or go to this website, once completed please provide: <https://www.caringinfo.org/wp-content/uploads/Arizona.pdf>]

Any allergies? [any and all including food or medications]

Do you drink alcohol? If so, any blackouts? Any consequences? Any seizures, hangovers, job loss, withdrawals, etc?

Have you ever misused prescription or recreational drugs? If so, please describe when it started, any sobriety time, how much for how often?

*** List any current or historical additional substance misuse.**

What emotions come up for you when you think about your substance use?

*** Do you have suicidal thoughts? Any gestures or attempts? If so, please describe how often and when the last time you felt or had thoughts of suicide.**

- ☐ Yes
- ☐ No
- ☐ Please describe details:

*** Have you ever thought about or attempted to kill yourself?**

- ☐ Never
- ☐ It was just a brief passing thought
- ☐ I have had a plan at least once to kill myself but did not try to do it
- ☐ I have had a plan at least once to kill myself and really wanted to die
- ☐ I have attempted to kill myself, but did not want to die
- ☐ I have attempted to kill myself, and really hoped to die

*** How often have you thought about killing yourself in the past year?**

- ☐ Never
- ☐ Rarely (1 time)
- ☐ Sometimes (2 times)
- ☐ Often (3-4 times)
- ☐ Very Often (5 or more times)

*** Have you ever told someone that you were going to die by suicide, or that you have thought about doing it?**

- ☐ No
- ☐ Yes, at one time, but did not really want to die
- ☐ Yes, at one time, and really wanted to do it
- ☐ Yes, more than once, but did not want to do it
- ☐ Yes, more than once, and really wanted to do it

*** How likely is it that you will attempt suicide someday?**

- ☐ Never
- ☐ No chance at all
- ☐ Rather Unlikely
- ☐ Unlikely
- ☐ Likely
- ☐ Rather Likely
- ☐ Very Likely

*** Any current or history of self harm? If yes, please explain in detail [such as any medical intervention needed, ways you self-harm, etc].**



*** Do you have thoughts or urges to harm others?**

- ☐ Yes
- ☐ No
- ☐ If yes, please explain:

*** Is there a history of mental illness in your family?**

- ☐ Yes
- ☐ No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Do you have any children? If so, how many? Age(s)?

Describe your current living situation. Do you live alone, with others. With family, etc...

*** Please indicate if you live in a sober living home, if so please provide the name of the sober living and their licensure number. If this does not apply to you please indicate NA.**

Please tell me about your social interaction. Have there been any major changes in your life or your family?

* What is your level of education? Highest grade/degree and type of degree./ Are you currently in school? If so what grade?

* What is your current occupation? What do you do? How long have you been doing it?

Current financial situation: (any problems, impulsive spending, unemployment issues, substantial debt)

Please tell me about your childhood, anything of importance? Where did you grow up? Did you feel supported in childhood? Feel safe? Tell me about the atmosphere in your home growing up. Do you feel you were supported? What was discipline like?

*** Any trauma or abuse?**

- ☐ Sexual trauma:
- ☐ Physical:
- ☐ Emotional:
- ☐ Domestic violence:
- ☐ TBI:
- ☐ History of other types of trauma (e.g., environmental, natural disasters, etc.)
- ☐ Other:

*** Any past or present legal issues, this can include DUIs, arrests, convictions, probation, etc.? If you do not have any legal issues please indicate NA.**

*** Do you have any preferences? Cultural, Dietary, Spiritual, Religious, Activity, Interpreter, etc:**

*** Any developmental concerns,? Past developmental issues, such as educational issues growing up? IEP? struggle in school? Speech issues? Dyslexia, reading issues, etc. ? If none of these applied to you please indicate NA.**

*** Please check any of the following you have experienced in the past six months**

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Trouble concentrating
- ☐ Difficulty sleeping
- ☐ Excessive sleep
- ☐ Low motivation
- ☐ Isolation from others
- ☐ Fatigue/low energy
- ☐ Low self-esteem
- ☐ Depressed mood
- ☐ Tearful or crying spells
- ☐ Anxiety
- ☐ Fear
- ☐ Hopelessness
- ☐ Panic
- ☐ Mood swings
- ☐ Feeling overwhelmed
- ☐ Stress
- ☐ Grief
- ☐ Feeling triggered
- ☐ Vivid dreams
- ☐ Food issues
- ☐ Safety issues
- ☐ Other:
- ☐ None apply

Do you experience any pain? If so, where, and how often?



Please check any of the following that apply

- ☐ Headache
- ☐ High blood pressure
- ☐ Gastritis or esophagitis
- ☐ Hormone-related problems
- ☐ Head injury
- ☐ Angina or chest pain
- ☐ Irritable bowel
- ☐ Chronic pain
- ☐ Loss of consciousness
- ☐ Heart attack
- ☐ Bone or joint problems
- ☐ Seizures
- ☐ Kidney-related issues
- ☐ Chronic fatigue
- ☐ Dizziness
- ☐ Faintness
- ☐ Heart valve problems
- ☐ Urinary tract problems
- ☐ Fibromyalgia
- ☐ Numbness & tingling
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid issues
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Other
- ☐ None apply

What are things you are passionate about? What are things you do for fun, or to wind down? Tell me about your interests

What else would you like me to know?

Date of most recent lab work. [If labs have been completed in past year please upload to chart]. If you do not have any recent lab work please indicate NA.

Please provide the date of your last menstrual period, and if you are currently pregnant, trying to get pregnant, or currently breastfeeding? If this does not apply please indicate NA.