Buffalo Grove Sleep and
Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

PSYCHOTHERAPY INTAKE QUESTIONNAIRE

Date: _____ **Provider: Mary Elizabeth Strain, PhD, CBSM**

NAME: _____

DATE OF BIRTH: _____ **AGE**: _____

If under the age of 18, who is your legal guardian? _____

ADDRESS: _____

_____

HOME PHONE: _____ Is it ok to leave a phone message? ____No ____Yes

CELL PHONE: _____ Is it ok to leave a phone message? ____No ____Yes

EMAIL: _____

Is it ok to email you regarding appointment times? ____No ____Yes

Referred by:

- o Self
- o Family
- o Friend
- o Doctor
- o Counselor
- o Advisor
- o Administrator
- o Name/or Other: _____

May I contact the person who referred you and inform them that you scheduled an appointment with me? ____No ____Yes

Emergency Contact Information:

Name: _____ **Relationship:** _____

Address: _____

_____

Home Phone: _____ **Cell Phone:** _____

Buffalo Grove Sleep and
Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

Please fill out this form as completely as possible. If you feel uncomfortable answering any of the questions or don't understand something, you may leave it blank. At our initial appointment, we will review your answers with greater depth and clarify your goals.

Please describe yourself as fully <u>as you feel comfortable</u>:

Gender:

_____Male _____Female _____Intersex _____Transgender

Race/Ethnicity:

_____African/African-American
_____Asian Pacific Islander/Asian American
_____Chicano(a)/Latino(a)/Hispanic
_____Native American/Alaskan Native
_____Persian
_____Arab/Arab-American
_____Caucasian/European-American
_____Mexican/Mexican-American
_____Southeast Asian/Southeast Asian American
_____Biracial/Bicultural: _____
_____Multiracial/Multicultural: _____
_____Other: _____

Relationship Status:

_____Single _____Married/Partnered _____Separated _____Divorced _____Widowed _____Other

Sexual Orientation:

_____Bi-sexual _____Gay/Lesbian _____Heterosexual _____Questioning

Languages Spoken: _____

Religious Affiliation/Spirituality: _____

Involvement: _____None _____Some/Irregular _____Active

Residence: _____Alone _____With others (please specify name, age, relationship):_____

_____

<u>SCHOOL INFORMATION:</u>

School Name: _____

Grade/Class Level: _____ **Major** (if applicable):_____

Buffalo Grove Sleep and Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

School Status: _____Full Time _____Part Time

EMPLOYMENT INFORMATION:

Employer: _____ # of Hours per Week_____

_____Full Time _____Part Time Other: _____

PRESENTING COMPLAINT:

Please check (highlight/bold if working on a computer) all issues that currently concern you:

- ☐ Academic/Work Problems
- ☐ Addiction Problems
- ☐ Adjusting to School/Work
- ☐ Alcohol Use
- ☐ Anxiety
- ☐ Assertiveness/ Empowerment
- ☐ Athletic Performance
- ☐ Attention Deficit Disorder
- ☐ Bipolar (Manic-Depression)
- ☐ Body Image
- ☐ Clarification of Own Values
- ☐ Coming-out Process
- ☐ Confidence
- ☐ Decision Making
- ☐ Decreasing Own Suicidal Thoughts
- ☐ Depression
- ☐ Difficulty Choosing a Career/Job
- ☐ Disordered Eating
- ☐ Eliminating/Reducing Unhealthy Behavior
- ☐ Ending an Important Relationship
- ☐ Financial Concerns
- ☐ Grief
- ☐ Identity Concerns Injury Recovery/Rehab
- ☐ Interpersonal Problems
- ☐ Internet/Gambling Addiction
- ☐ Life Transition
- ☐ Multi-cultural Concerns
- ☐ Obsessions/ Compulsions
- ☐ Physical/Medical Concern
- ☐ Relationship Problems
- ☐ Self-Acceptance/Esteem
- ☐ Self-care (hygiene, taking time for self)
- ☐ Self-Understanding
- ☐ Sexual Health Issues
- ☐ Sexual Orientation
- ☐ Sleep Disturbances
- ☐ Stress Management
- ☐ Substance Use
- ☐ Working through a Traumatic Events (s)
- ☐ Other (specify): _____

_____

Please check (highlight/bold if working on a computer) all of the following that you have experienced:

☐ = **Recent (within the last month)** ○= **Past (one month ago or longer)**

- ☐ ○ Change in appetite
- ☐ ○ Significant weight gain/loss
- ☐ ○ Change in mood
- ☐ ○ Irritability
- ☐ ○ Feelings of worthlessness
- ☐ ○ Changes in Sleeping Patterns
- ☐ ○ Loss of energy
- ☐ ○ Loss of interest in activities
- ☐ ○ Loss or decrease in sexual interest
- ☐ ○ Lost or irregular menstrual cycle
- ☐ ○ Increase of energy
- ☐ ○ Difficulty concentrating
- ☐ ○ Nightmares
- ☐ ○ Substance abuse (alcohol or drugs)
- ☐ ○ Problems with attention, motivation, memory
- ☐ ○ Recurrent and excessive anxiety or worry
- ☐ ○ Feelings of restlessness
- ☐ ○ Trembling or shaking
- ☐ ○ Accelerated heart rate

Buffalo Grove Sleep and Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

- ☐ ○ Shortness of breath
- ☐ ○ Sweating
- ☐ ○ Chest pain
- ☐ ○ Feelings of choking
- ☐ ○ Nausea
- ☐ ○ Recurrent thoughts of death
- ☐ ○ Recurring thoughts of wanting to commit suicide
- ☐ ○ Recurring thoughts of harming others
- ☐ ○ Cutting, pinching, or burning myself
- ☐ ○ Seeing things that others do not
- ☐ ○ Hearing voices that others do not
- ☐ ○ Paranoid thoughts
- ☐ ○ Others (specify):_____

_____

Which of the above difficulties brought you in to see me today?

When did you start having a problem with this?

Have you ever sought counseling for this concern in the past? _____No _____Yes

If yes, when and for how long?

Have you ever sought counseling for any other concern in the past? _____No _____Yes

If yes, when and for how long?

For what concern?

Have you found counseling helpful in the past? _____No _____Yes

Have you ever been hospitalized for mental health treatment? _____No _____Yes

If yes, was it voluntary? _____No _____Yes

Have you ever been admitted to residential or intensive outpatient services? _____No _____Yes

If yes, where and for how long?

SUICIDAL/HOMOCIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

Have you ever had…	*Current (if yes, describe)*	*Past (if yes, describe)*
Thoughts of hurting yourself?	N Y	N Y
Thoughts of suicide?	N Y	N Y

Buffalo Grove Sleep and
Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

A plan for suicide?	N	Y	N	Y
An attempted suicide?	N	Y	N	Y
Thoughts of hurting someone else?	N	Y	N	Y
An incident of actually hurting someone else?	N	Y	N	Y

Has anyone in your family or any of your friends attempted suicide? _____No _____Yes

Has anyone in your family or any of your friends completed a suicide? _____No _____Yes

STRENGTHS AND COPING STRATEGIES:

How have you coped with your presenting concern so far?

What strengths do you bring to this problem that will assist you in overcoming it?

Describe your support systems (friends, family, spiritual, or cultural groups, etc.):

Are they nearby? _____No _____Yes

FAMILY HISTORY:

Are your parents married/separated/divorced/remarried?

If divorced, how old were you at that time?

With whom did you live as a child?

Did you experience any major transitions or moves in your past?

Have you lost any direct family members? _____No _____Yes

Please list:

Buffalo Grove Sleep and
Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

Do any family members (parents, sibling, grandparents, etc.) have a history of mental illness (depression, anxiety, etc.? _____No _____Yes

Please list:

Is there a history of alcoholism/substance abuse in your extended family? _____No _____Yes

Who?

TRAUMA HISTORY:

Have you ever been a victim of a crime? _____No _____Yes

Have you ever experienced physical trauma (e.g., car accidents, assault, abuse, head trauma)?

Have you ever experienced emotional trauma (e.g., victim of crime, abuse, loss or death of relative/friend)?

Have you ever experienced sexual trauma (e.g., sexual harassment, sexual assault)?

LEGAL HISTORY: Have you ever been arrested or convicted of a legal violation? _____No _____Yes

MEDICAL HISTORY:

Have you ever experienced a head injury? _____No _____Yes

Please describe:

Have you ever lost consciousness? _____No _____Yes

Please describe:

Have you ever had any surgeries? _____No _____Yes

Please describe:

Have you ever been hospitalized for a medical condition? _____No _____Yes

Please describe:

Buffalo Grove Sleep and Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

Please list current medications and dosage:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

From whom do you get your prescriptions for your psychotropic (e.g., antidepressant) medications:

Clinic/Doctor's name**:** _____ Phone #: _____

Address: _____

SUBSTANCE USE HISTORY: Please indicate your use of the following substances:

Substance:	Current Use		Past Use	
	Frequency # of days per week	Amount Per Day	Frequency # of days per week	Amount Per Day
Alcohol	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs (please list)	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Other (please list)	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

When was the last time you used any drugs and/or alcohol? _____

When was the last time you had more than 4 drinks on 1 occasion? _____

Have you ever experienced a black out from drinking too much alcohol? _____No _____Yes

If yes, how often? _____ Date of last black out? _____

Have you ever tried to cut down or stop your alcohol and/or substance use? _____No _____Yes

Were you successful? _____No _____Yes

Do other people consider your alcohol and/or substance use a problem? _____No _____Yes

YOU'RE ALMOST DONE!

Buffalo Grove Sleep and
Behavioral Health

355 W. Dundee Road
Buffalo Grove, IL 60089
Phone: (847) 920-7888
Fax: (312) 631-2878
bgsleep.com

Is there anything else that you think is important for me to know about? If yes, please describe:

How much reluctance do you have about coming in for therapy? Please circle one:

_____1_____2_____3_____4_____5_____

No reluctance at all *Some reluctance* *Strong reluctance*

How motivated are you to make changes related to improving your presenting concern? Please circle one:

_____1_____2_____3_____4_____5_____

No motivation at all *Some Motivation* *Strong Motivation*

PLEASE DESCRIBE YOUR GOALS FOR THERAPY: