Running Creek Counseling
Intake Record

Name: Address:
City: State: Zip: Age:_______ Birth Date:
Phone (Cell) Gender: Ethnicity/Race:
(Home): E-mail:
Marital Status: #of Previous Marriages Length of each: #1_____#2_____#3____#4____
Are there aspects of your cultural background that may impact your treatment?
Current Employer: Occupation/Title:
Length of Employment: Hourly or monthly Income: (Must bring last 2 paystubs for sliding scale)
Military Branch: # of years: Rank at Discharge:
Type of D/C: Status:
Medications: list all you are taking, the doses, and what you take them for:

Current Partner's Name: Address:
City: State: Zip: Age: Birth Date:
Phone (Cell) Age: Gender: Ethnicity/Race:
(Work): E-mail: Marital Status:
How Long:

Children (List all children under age 18):
Name Gender Age

How much? Are you current?
Do you pay Child Support?**Emergency Notification/**
Relationship: How did you get referred for services?

Services Requested:

Pre-trial/Probation Officer: Judicial District/Dept.:
Case Number: Caseworker: County:

Domestic Violence Clients Must Complete __**If Different**__ **Than Current Partner**
Victim: : Address:
City: State: Zip: Age: Birth Date:
Phone (Cell) Gender: Male Female Ethnicity/Race:
(Home): E-mail: Marital Status:
Type of Protection Order/Restraining Order:

Psychosocial History

Where were you born: Were you raised by bothparents?
If not, who did you live with: Were your parents:
How many siblings do you have: Where are you in the birth order?
Who in your family do you feel closest to:
Please describe your childhood:

Please describe how you were disciplined as a child:

Was there any violence, alcoholism, substance abuse in your family? (Include extended family)Describe:

Have you ever been abused? Physically: Emotionally: Verbally: Sexually:
If yes, please describe:

Has anyone close to you died? Relationship: Cause of death:
How long have you been in your current relationship status?
Describe your partner:
Describe your partner's attitude toward you:
How many serious relationships have you had? How many times have you been married?
Have you been divorced or separated? How long was your longest relationship?
How do you feel about your partner?
Who do you prefer relationships with?

Give **your ages** and the **names** of the individuals you have been married to:

From what age to what age?	Partner's name

Provide the following information on your **biological** children:

Name	Gender	Age	Where living	Name of other parent

Please list any other children who are living with you:

Name	Gender	Age	Names of biological parents

What have been your usual living arrangements over the past three years?

What are your current living arrangements (use above list)?

How long have you lived in these arrangements? Are you satisfied with these arrangements?

Are you satisfied with these arrangements?

Do you live with anyone who: has a current alcohol problem?
uses non-prescribed or illegal drugs?
abuses prescribed drugs?

With whom do you spend most of your free time?

Are you satisfied with these arrangements?

About how many close friends do you have?

Would you say you have a close reciprocal relationship with any of the following people:

Your mother
Spouse/Sexual partner
Siblings
Your father
Children
Friends

Have you had significant periods in which you have experienced serious problems getting along with:

	In the past 30 days	In your lifetime
Your mother		
Your father		
Siblings		
Children		
Close friends		
Sexual partner/Spouse		
Other family members (specify)		
Neighbors		
Co-workers		

How many days in the last 30 have you had serious conflicts: with your family?
with other people (excluding your family)

How bothered have you been in the past 30 days by:
Family Problems
Social Problems

How important is treatment for:
Family Problems
Social Problems

Employment and Educational History

How many years of education have you completed? (GED = 12 years, BA=16 years)

Did you have learning difficulties in school?
If yes, briefly explain:

Have you ever been expelled/suspended from school?
If yes, for what:

How many years of job training or technical education have you received?

Are you currently working? Are you satisfied with your current job?

If unemployed, how long have you been unemployed? What was your last job?

Do you have a profession, trade or skill? If so, please specify
Do you have a valid driver's license? Do you have an automobile available?
How long was your longest full-time job?
What is your usual, or last occupation?

Does someone contribute to your support in any way?
If so, does this constitute the majority of your support?
What has been your usual employment pattern the past three years?

How many days were you paid for working in the past 30 days?

How much money did you receive from the following sources in the past 30

Unemployment	$
Child Support	$
Maintenance	$
Unemployment compensation	$
Welfare, disability benefits	$
Pensions, Social Security	$
Partner, family or friends	$
Illegal sources	$

How many people depend on you for the majority of their food, shelter, etc.?
How many days have you experienced employment problems in the past 30 days?

How troubled have you been by employment problems in the past 30 days?

How important is counseling for employment problems?

Are you a military veteran? Branch? Rank at discharge:

Years served Did you see any action during war time?

If yes, where?

Discharge Status If other please specify:

Legal History

How many times have you been arrested and/or ticketed?
Please list dates and reasons for arrest

Describe the reasons you were arrested and/or sent here, **IN DETAIL** (include drug or alcohol use involved)

How many times in your life have you been arrested and/or ticketed with the following:

Shoplifting/Vandalism	Robbery	Drug Charges	Homicide
Parole/Probation Violation	Forgery	Breaking & Entering	Prostitution
Burglary/Larceny	Rape	Arson	Manslaughter
Weapons Offense	Assault	Contempt of Court	

Other (Please Specify)

How many of these charges resulted in convictions?

How many times in your life have you been charged with the following? (Do not include minor traffic tickets)
Disorderly conduct, vagrancy

Public intoxication violations

What has been your highest measured Blood Alcohol Level?
How many months were you incarcerated in your life?
How long was your last incarceration? What was it for?
How many days in the past 30 were you detained or incarcerated?
How many days in the past 30 have you engaged in illegal activities for profit?

How serious do you feel your present legal problems are?
How important to you is counseling for these legal problems?

Behavior Checklist

Please check all you have done:

Slapped/hit your partner or children

Shoved your partner or children

Mocked your partner or children

Withheld affection/sex

Broken propery

Thereatened to leave or divorce partner

Became more angry as a result of drinking and/or drugs

Threatened to hurt your partner

Threatened or hurt pets

Kicked your partner or children

Called your partner or children names

Shoved/pushed your partner or children

Punched walls

Restrained your partner/another person

Drank or did drugs to relieve anger

Threatened someone with a weapon

Threatened to hurt your children

Threatened other people

What experiences have you witnessed:

Parents hitting/hurting each other

Parents hitting/hurting you

War

Street Crime

Describe the last fight you were in (when, with whom, where, etc.)

Substance Use History

What is the most of any substance you have ever used?

Have you ever felt you needed to cut down on your drinking or drug use?

If yes, briefly explain:

Which substance do you see as the major problem for you?

What is the longest time you have remained drug/alcohol free?

How long was your last period of voluntary abstinence from this major substance?

How many months/years ago did this abstinence end?

Have you ever experienced withdrawal symptoms several hours to several days after stopping or reducing your drug or alcohol use?

If yes, please indicate the symptoms you have experienced:

☐ Tremors, shakiness ☐ Sleep problems (too much/too little) ☐ Achy joints/muscles
☐ Nausea, vomiting or diarrhea ☐ Anxiety, depression or irritability ☐ Poor concentration
☐ High Fever ☐ Sweating ☐ Runny nose or eyes
☐ Little or no energy ☐ Significant increase/decrease in appetite ☐ Headaches
☐ Significant weight loss/weight gain ☐ Seeing or feeling things that aren't there
☐ Increased heart rate or blood pressure

Have you ever "blacked out" or lost periods of time when using drugs and/or alcohol?

Have you ever drank or used more than you intended?

Have you ever experienced personality changes? Yes, explain:

Have you noticed that throughout your use history you have needed to use more drugs and/or alcohol to get drunk or high?

Have you ever received complaints from your family, friends, employer or others around you concerning your drug and/or alcohol use, or concerning your behavior while using?

Have you ever stole, snuck, or hid drugs and/or alcohol?

Please indicate the number of times you have had prior treatment for a drug/alcohol problem at the following:

Detox unit is Halfway House DUI Class Out Patient Residential

List the programs or agencies in which you have been in treatment for a drug and alcohol problem

Program Name Year

Have you ever attended Alcoholics Anonymous or other recovery programs?

If yes, type:

How much money would you say you spent during the last 30 days on Alcohol? Drugs?

How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days?

How many days have you been treated as an inpatient for alcohol or drugs in the past 30 days?

How many days have you drank/used in the past 30 days? Alcohol Drugs

What Substances?

Describe the consequences you have experience from you drug or alcohol use.

Legal Consequences

Personal Consequences

How troubled/bothered have you been in the last 30 days

Alcohol Drugs

How important to you is treatment for:

Alcohol Drugs

History of Mental Illness/Treatment

Are you currently in counseling or mental health treatment?

If yes, with what person/agency?

How long have you been in counseling? How often?

How many times have you been treated for any psychological/emotional problems?

(Do not include substance abuse, employment or family counseling)

In a hopital or inpatient setting? When? Where?

With Whom? What for?

In an Outpatient setting? When? Where?

With Whom? What for?

Do you receive a pension for a psychiatric disability?

Have you had a period of time(not as a result of alcohol/drug use) during which you have:

	In the past 30 days?	In your lifetime?
Experienced serious depression, sadness, hopelessness, loss of interest, or difficulty with daily functioning?		
Experienced serious anxiety/tension/uptightness, unreasonable worry, or inability to feel relaxed?		
Experienced hallucinations-saw things or heard voices that were not there?		
Experienced trouble understanding, concentrating, or remembering?		
Experienced trouble controlling violent behavior, or episodes of rage or violence, including when you have been under the influence of alcohol or drugs?		
Experienced serious thoughts of suicide?		
Attempted suicide?		
Are you still thing about suicide?		
Were drugs and/or alcohol involved in any of your attempts?		
Thoughts of killing someone?		
Been prescribed medication for any behavioral health problem?		

How many days in the past 30 days have you experienced these behavioral health problems?

If you have had thoughts of suicide, please describe your plan for attempting suicide:

What was going on in your life when these thoughts occurred?

How much have you been troubled/bothered by these behavioral health problems in the last 30 days?

How important to you is treatment for these behavioral health problems?

Health Related Issues/Medical Information

How would you rate your health?

Are you currently under medical care? For what reason?

Name of your doctor/clinic

Last doctor visit?

Do you have any chronic medical problems which continue to interfere with your life?

If yes, please describe

What treatment, if any, have you received for this problem?

How many times in your life have you been hospitalized for medical problems?

Hospitalizations and dates

Surgeries and dates

How long ago was your last hospitalization for a physical problem?

List all allergies or adverse drug reactions you have:

Do you receive a pension for a physical disability?

How many days have you experienced medical problems in the past 30 days?

When was your last physical exam (including pap smear if you are female)?

What were the results/recommendations?

What is the name and address of your current physician?

Please indicate if you had any of the following symptoms:

Symptoms

Frequent or severe headaches

Eye problems, glaucoma Dizziness or fainting spells

Head injury

Thyroid trouble

Chronic fatigue

Asthma/shortness of breath

Chronic cough/lung disorders

Palpitation or pounding heart

Heart attack/heart trouble

High blood pressure

Kidney disease

Stroke

Jaundice/liver disorder

Arthritis/gout Tumors

Depression

Constant irritability

See/hear things that weren’t there

Feeling as if your heart were racing

Symptoms

Recent weight loss or gain(circle one)

Diabetes

Anemia

Frequent/painful urination

Stomach/bowel disorders

Paralysis

Epilepsy or seizures

Neurological disease

Change in memory or concentration

Male or female reproductive problems
(i.e. menstrual pattern changes
prostate trouble)

ADD/ADHD

Anxiety

Bi-polar

Broken Bones

Bronchitis

Cancer

Chicken Pox

Dyslexia

Eye glasses/Contacts

Hearing Loss

Hypertension

Hypo(er)glycemia

Learning Disabilities

Measles

Multiple Sclerosis

Problems Sleeping

Sinus Problems/Infections

Substance Abuse

Ulcers

Please list any other diseases or conditions you have had or have now not listed above

If you have ever had any of the symptoms listed above, please provide as much of the following information as possible: date of occurrence, duration of illness, symptoms, whether or not treatment was sought, treatment received, results of treatment, and physician's name. If you did not seek treatment, what was the outcome?

Have you ever had any of the following health problems? (Check those that apply)

Hepatitis | Venereal Warts | Chlamydia | Tuberculosis
Syphilis | Pelvic Inflammatory Disease | Gonorrhea | Genital Herpes

How troubled or bothered have you been by medical problems in the past 30 days?

How important to you is treatment for medical problems?

Are you currently a smoker? How much do you smoke daily?

Please indicate your family's medical history:

Names	**Ages**	**Mental Health Diagnosis**	**Alcohol/ Drug Use**	**Medical Problems**	**Cause of Death/ Year if Deceased**
Name of your Biological Father:					
Name of your Biological Mother:					
Names of your Brothers and Sisters:					

This Section for Females Only How many

How many times have you been pregnant?

How many times have you actually given birth?

How old were you when your first baby

Are you currently pregnant? If yes, how far along are you?

If yes, are you receiving pre-natal care?

Have you ever experienced medical complications in childbirth?

If yes, please describe:

Strength Checklist

Everyone has certain personal characteristics that make us unique and enhance our ability to perform different tasks successfully. Please review the characteristics below and check all of the characteristics you have:

Accurate
Committed
Creative
Emotional
Good Attitude
Inquisitive
Loyal
Persuasive
Responsible
Sense of Humor
Trustworthy
Adventurous
Communicate Well
Civic Minded
Sensitive
Perfectionist
Productive
Self-controlled
Other (Please specify)

Artistic
Self-controlled
Dedicated
Entertaining
High Standards
Intuitive
People-oriented
Practical
Self-assured
Sociable
Curious
Energetic
Hard Worker
Intelligent
Original
Physically Fit
Responsive

Challenging
Confident
Efficient
Expressive
Independent
Levelheaded
Personable
Rational
Self-starter
Tolerant
Assertive
Compassionate
Dependable
Enthusiastic
Imaginative
Good Leader
Stable

Please indicate your history of drug and alcohol use.

Substance	How old were you when you first used it?	When was your last use?	Over the last year, how often have you used the substance? (i.e. every day, once a week, etc.)	Over the last year, what is the normal amount you use in a 24 hr. period of time?	What is the most you have <u>ever</u> used in a 24 hr. period of time?	How have you used it?
NICOTINE Cigarettes, Cigars, Chew						
ALCOHOL Beer, Wine						
ALCOHOL Hard liquor						
CANNABIS Marijuana, Hash, Oils						
COCAINE Rock, Crack, Powder						
METHAMPHETAMINE Crystal Meth, Crank, Ice						
AMPHETAMINE Speed, Diet pills, White crosses						
HALLUCINOGENS LSD, Ecstasy,Acid, Mushrooms, Peyote						
OPIATES Morphine, Heroin, Opium, Methadone						
PAIN PILLS Demerol, Darvon, Percocet, Percodan, Xanax, Tylenol with Codeine						
SEDATIVES Downers, Reds, Yellows, Quaaludes, 714s						
TRANQUILIZERS Valium, Xanax, Ativan						
INHALANTS Gas, Glue, Solvent, Paint, Poppers, Rush						
PCP Angel Dust						
OTHER(please list)						
OTHER(please list)						