Family Information

Please list additional family members living with you:

NAME	RELATIONSHIP	DATE OF BIRTH	WORK/SCHOOL	SOC. SEC. #

INSURANCE PLAN	
ID NO.	GROUP NO.
PROVIDER CUSTOMER SERVICE PHONE NUMBER	

Have you ever been hospitalized for a mental or nervous problem? No Yes
If yes, when and where?____

Have you ever attempted suicide? No Yes
If yes, where, when and how many attempts?______________________________

Are you suicidal now? No Yes

Do you drink alcohol? No Yes
If yes, what if your typical drink and how often do you drink alcohol?__________
Age first used alcohol_______ Age of heaviest/most frequent use______ Use in last three months______

Have you ever been arrested? No Yes
If yes, how many times and for what?___________________________________

Are you currently involved, or do you expect to be involved in any court-related matters? No
Yes If yes, please describe____
____
____
____

What important things about your marriage or family would it be helpful for your therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)____________
____
____
____
____
____

Do you have any concerns about violence or abuse in your family? Alcohol or drug usage?
Please describe them. ____
____
____
____
____

Is there any history of mental health issues in your family? (depression, suicide, Bipolar Disorder, anxiety, substance abuse)? ____
____
____
____
____

INTAKE INFORMATION

Client Name____________________ Social Security #____________________
Address____________________ Birthdate____________Age______
City__________State__________Zip______ Marital Status: Single______
Phone home__________ Work__________ Married Since______
May we call you at work? Yes____No____ Separated Since______
Work Schedule(hours)____________________ Divorced Since______
Education(years completed)____________ # of previous marriages______
Occupation____________________ Date of divorce or deaths______
Place of Employment____________________ ____________________
Employment Address____________________ Gender: Male Female
Length of Employment____________________ Annual Income____________

Who referred you to Three Rivers?__________ Religious preference____________
May we thank this person? Yes____No____
Referral Address______________________________

Child/Client Information:
If the Client is a child please answer the following questions:

Child's Name____________________ Social Security # ____________
Birthdate____________ Age______ Nickname____________
Child's address(if different from parent)______________________________
School__________Teacher's name__________ Phone____________
Grade currently in__________ Pediatrician______________________________

I understand that by signing below I am giving my consent for my child to be seen and am certifying that I am the child's legal guardian and am authorized to give consent.

____
Parent/Guardian Signature

Spouse/Partner Information:

Client Name____________________ Social Security #____________________
Address____________________ Birthdate____________Age______
City__________State__________Zip______ Marital Status: Single______
Phone home__________ Work__________ # of previous marriages______
May we call you at work? Yes____No____ Date of divorce and deaths______
Occupation____________________ Dates of military service____________
Place of Employment____________________ Annual Income____________
Length of Employment______________________________
Religious Preference______________________________

Number of older brothers/sisters________ Number of younger brothers/sisters______

Please describe what your life was like while growing up:______________________________
____
____
____

Was your family lower, middle, or upper income/class?___________________________

Did your family go to church?___________Did you grow up in a rural area or city?__________

EDUCATION:

Years of school completed_______________ Highest Degree___________
Typical Grades_________________ Did you receive special education services? Yes No

EMPLOYMENT:

How many places have you worked in the past five years?____________

Are you currently employed? No Yes If yes, where do you work and how long have you worked there?____

If you are not employed, are you:
_____Looking for work, ____Retired,_____Not looking for work
_____Unable to work (please describe)______________________________________
____
____

SOCIAL AND LEISURE ACTIVITIES:

Please list your favorite leisure activities.____________________________________
____
____

Please list social and community organizations to which you belong.________________
____
____

MILITARY EXPERIENCE:

Did you serve in the Armed Forces? No Yes

PAST AND CURRENT LEGAL INVOLVMENT:

Do you have past legal convictions? No Yes

Are you currently on probation or parole? No Yes

Do you have pending legal charges? No Yes

ADDITIONAL INFORMATION:

Do you have a spiritual or religious belief?____

Did you mother have you by natural child birth?____
Did she have complications?____

How old were you when you crawled?_____Walked?_____Said full sentences?_____Potty trained?_____

Have you lost a loved one, job, marriage, pet, health, or finances in the last twelve months?____
____
____

Please describe any additional information you feel is important to know.___________________
____
____
____
____
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____

ADULT INFO. FORM

Name________________________ DOB__________ Age______________

Completed by: Self Other(Name____________________) Date______________

PRESENTING PROBLEMS:

Please describe the problems for which you are seeking help.______________________

About when did these problems start?______________________

Do these problems seem related to something that's happened in your life? No Yes
If yes, please describe.______________________

Are there times when these problems seem less or more intense? No Yes If yes, please describe.______________________

HARM CONCERNS:

Do you currently have thoughts of harming yourself in any way? No Yes
In the past, did you have thoughts of harming yourself or attempt to harm yourself in any way?
No Yes

Do you currently have thoughts of harming someone else in any way? No Yes

Do you have a history of violence towards others? No Yes

Have you ever been emotionally, physically, or sexually abused? No Yes

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MENTAL HEALTH AND SUBSTANCE ABUSE INFO FOR SELF/FAMILY

Please list all precious outpatient and inpatient mental health or substance abuse treatment you received.

Name of place	Location	Dates

Were there things that were especially helpful from any past treatment? No Yes
If yes, please describe______________________________

____

____

____

Please list any psychiatric medications you took in the past but aren't taking now.

Name of Medication	Reason	Prescribed by	Dates

Please list any family history of mental health/substance abuse problems/treatment for grandparents, parents, uncles/aunts, and siblings.______________________________

____

____

____

____

____

Have friends or family members attempted or committed suicide? No Yes
If yes, please describe______________________________

____

____

____
____

Alcohol, Drug, and Tobacco Use:

Do you currently use alcohol? No Yes
Do you currently use street drugs? No Yes
Have you used street drugs in the past? No Yes
Have you use alcohol in the past? No Yes
Do you currently use tobacco? No Yes
Have you used tobacco in the past? No Yes

____
____
____

Current Medical Information:

Please list any major physical illnesses or problems:____________________________
____
____

Please list any drug allergies or adverse reactions to medications:____________________
____
____

Who is primary care physician? When and why did you last see your physician?__________
____

Please list all prescription medications you are currently taking.

Name of medications	Purpose	Prescribed by

Psychosocial History:

Current living situation:

Marital Status: ______ Single, ______ Married, ____ Live-in, ______ Separated, __ Divorced, ______ Widowed

Name of spouse/significant other:____
Years married or together:_________

Number of previous marriages______ Number of previous live-in relationships___

Children/step children:

Name	Gender	Age	Living with you?

Background Information:

Please indicate if you were primarily raised by:

Biological mother __________ Biological father ___________
Step mother ________ Step father _________
Adoptive mother ___________ Adoptive father ____________
Foster mother _____________ Foster father ________
Grandmother _____________ Grandfather_________
Aunt_______________ Uncle_______
Other____

SYMPTOMS CHECKLIST:

Name____

Date________________________

Circle all that apply:

Anger/Aggressiveness
Anxiety
Appetite Disturbance
Cognitive Impairment
Decreased Energy
Delusions
Depression
Dissociation
Elevated Mood
Fatigue
Hypersomnia
Hallucinations
Hopelessness
Hyperactivity
Grief
Impulsivity
Insight and Judgement Problems
Obsessions and Compulsions
Oppositional Defiant
Memory Problems
Panic Attacks
Paranoia
Poor Concentration
Pressured Speech
Severe Mood Swings
Sleep Disturbance
Body Complaints
Substance Abuse, Past or Present
Thoughts of hurting yourself or someone else?

Christy L. Foos, LSCSW, LCAC, Department of Transportation Substance Abuse Professional

INDIVIDUAL CONCERNS

Name: ______________________ DOB ______________________

Check any of the following terms that apply to you (S=Self) or to a family member (F=Family).

S	F	
☐	☐	Depressed Mood
☐	☐	Lost interest or pleasure
☐	☐	Lack of Energy
☐	☐	Significant Weight Gain/Loss
☐	☐	Inability to Concentrate
☐	☐	Excessive Sleeping
☐	☐	Difficulty Sleeping
☐	☐	Decreased Need for Sleep
☐	☐	Pressure to Keep Talking
☐	☐	Racing Thoughts
☐	☐	Difficulty Controlling Worry
☐	☐	Worry about Many Things
☐	☐	Panic Attacks
☐	☐	Excessive fear of situation or Object
☐	☐	Aggressive Behavior Toward Others
☐	☐	Reoccurring Thoughts and Impulses
☐	☐	Destroying Property
☐	☐	Witnessed/Experienced an Event Threatening Life or Serious Injury
☐	☐	Significant Ongoing Physical Pain
☐	☐	Stomach Problems
☐	☐	Headaches
☐	☐	Guilt About Many Things
☐	☐	Problems with self-worth
☐	☐	Isolation
☐	☐	Divorce
☐	☐	Legal Problems

S	F	
☐	☐	Bowel Problems
☐	☐	Problems Making Decisions
☐	☐	Problems with Agitation, or Restlessness
☐	☐	Learning/Academic Problems
☐	☐	Risk-taking Behavior
☐	☐	Feeling Lethargic
☐	☐	"On the Go" Behavior
☐	☐	Impulsive Behaviors
☐	☐	Repetitive Behaviors due to Stress
☐	☐	Temper
☐	☐	Alcohol Use
☐	☐	Drug Use
☐	☐	Frequent lying/deceitfulness
☐	☐	Problems Following Rules
☐	☐	Hear/See Things Others Do Not
☐	☐	Suicidal Thoughts
☐	☐	Sexual Problems
☐	☐	Problems Eating
☐	☐	Nightmares
☐	☐	Affair
☐	☐	Problems with ex/spouse
☐	☐	Feelings of Hopelessness
☐	☐	Loneliness
☐	☐	Insecurity
☐	☐	Separation
☐	☐	Parenting Problems

If you have noticed any recent changes in the following areas, please circle those areas.

THINKING *HEARING* *BALANCE* *SPEECH* *MEMORY* *ENERGY*

SLEEPING *MENSTRUAL CYCLE* *EATING* *SEXUAL ACTIVITY*

List all medications you are taking:

Medication	Dosage	Prescribed by	Date prescription began

____
____
____

Please list any counseling or therapy you or a member of your family are receiving:

Therapist	Address	When	Family Member(s)