Indianapolis Trauma Therapy Center

Trauma and Attachment Therapy
Psychotherapy, Consultation, Training

INTAKE FORM

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. To better understand how to serve you, we need to collect some information. Although this is a long form, many items only require a checkmark. We hope it will go quickly for you and sincerely appreciate you helping us get to know you.

General Information

First Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender _____

Street Address _____

City/Town _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Email _____

Emergency Contact

First Name _____ Last Name _____

Phone _____ Relationship _____

Do you authorize this person to discuss care with this office in the case of emergency?

( ) Yes ( ) No Signature_____

Current Service Providers

Therapist/Counselor _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Do you authorize ongoing updates to be provided to your therapist/counselor?

( ) Yes ( ) No Signature_____

Primary Care Physician _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Do you authorize ongoing updates to be provided to your primary care physician?

( ) Yes ( ) No Signature_____

Mental Health Status

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

What are your treatment goals?

_____
_____
_____
_____
_____

Current Symptoms Checklist

Check once for any symptoms present, twice for major symptoms

___ Depressed mood	___ Excessive talking	___ Unreasonable fear
___ Change in appetite	___ Racing thoughts	___ Fear of social situations
___ Not enough sleep	___ Easily distracted	___ Repetitive thoughts/behaviors
___ Too much sleep	___ Over working yourself	___ Intrusive thoughts/memories
___ Fatigue/sluggish	___ Impulsive behavior	___ Recent loss/grief
___ Agitated	___ Tense/unable to relax	___ Work/school problems
___ Excessive energy	___ Excessive worry	___ Violent thoughts/behaviors
___ Difficulty concentrating	___ Panic attacks	___ Self-harm
___ Inflated self-esteem	___ Afraid to leave home	___ Anger outburst(s)
___ Feeling worthless	___ Excessive guilt/shame	___ High-risk behavior
___ Feelings of hopelessness	___ Hallucinations	___ Homicidal thoughts
___ Suicidal thoughts	___ _____	___ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If yes, please answer the following. If no, please skip to the next section.

Do you ***currently*** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts?

_____
_____
_____
_____

When was the last time you had thoughts of dying?

_____
_____
_____
_____

Has anything happened recently to contribute to your feeling this way? ( ) Yes ( ) No. If yes, explain_____
_____
_____ On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

What do you think would make your life better?

_____
_____
_____

Have you ever thought about how you would kill yourself? ( ) Yes ( ) No. If yes, is the method you would use readily available? _____ Have you planned a time for this? ( ) Yes ( ) No. Explain_____
_____

Is there anything that would stop you from killing yourself? ( ) Yes ( ) No. Explain:

_____
_____
_____
_____

Have you ever tried to kill or harm yourself before? ( ) Yes ( ) No. If yes, please provide dates and history of previous attempts

_____
_____

Do you have access to guns? ( ) Yes ( ) No. If yes, please explain.

_____

Medical History

Allergies (including any essential oils): _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements:

_____

_____

_____

Current medical problems:

_____

_____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____

_____

_____

Date and place/physician of last physical exam:

_____

When your mother was pregnant with you, were there any complications during pregnancy or birth? ( ) Yes ( ) No. If yes, explain:

_____

_____

_____

_____

Mental Health History

Have you had previous outpatient therapy or counseling? ( ) Yes ( ) No. If yes, describe when, by whom, and nature of treatment:

Date(s) By Whom Treatment

Have you had previous outpatient treatment by a psychiatrist? ( ) Yes ( ) No. If yes, describe when, by whom, and reason for treatment.

Date(s) By Whom Treatment

Have you ever been hospitalized for psychiatric reasons (include residential treatment)? ( ) Yes ( ) No. If yes, describe when, where and for what reason.

Date(s) Facility Reason Hospitalized

Family Psychiatric History

Has anyone in your family been diagnosed or treated for:

Anger	( ) Yes ( ) No	Depression	( ) Yes ( ) No
Alcohol/Substance Abuse	( ) Yes ( ) No	Post-traumatic Stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Bipolar Disorder	( ) Yes ( ) No	Other_____	( ) Yes ( ) No

Substance Use:

Describe your alcohol use:

_____
_____
_____
_____

How many days per week do you drink alcohol? _____

Have you ever been concerned about your drinking? ( ) Yes ( ) No. If yes, please describe:

_____
_____

Have you ever attempted to control, manage or decrease your drinking with or without success?

( ) Yes ( ) No. If yes, please describe:

_____
_____

Describe your use of recreational drugs:

_____
_____
_____
_____

Have you used street drugs in the past three (3) months? ( ) Yes ( ) No. If yes, what kind?

_____

Have you ever abused prescription medication? ( ) Yes ( ) No. If yes, what kind and for how long?

_____

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No.

If yes, for which substances? _____
If yes, where were you treated and when? _____

_____
_____
_____
_____

Describe your use of tobacco:

_____
_____
_____
_____

Social Emotional History

Were you adopted? ( ) Yes ( ) No Birthplace _____
Where did you grow up?_____
List your siblings and their ages:

_____
_____
_____

What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No. If so, how old were you when they divorced? _____
If your parents divorced, with whom did you live? _____

Describe your father and your relationship with him:

_____
_____

Describe your mother and your relationship with her:

_____
_____

How old were you when you left home? _____
Has anyone in your immediate family died? ( ) Yes ( ) No. If yes, please share who, when and how this has impacted you:

_____
_____

Do you have a history of being abused? ( ) Yes ( ) No. Please circle all that apply: emotionally, sexually, physically or by neglect? If you feel comfortable sharing, please describe at what age and by whom:

_____
_____
_____
_____

Are you currently (Please check) ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? _____ If not married, are you currently in a relationship? ( ) Yes ( ) No. If yes, how long? _____ Describe your relationship with your spouse or significant other:

_____
_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many and how long?

_____

Do you have children? ( ) Yes ( ) No. No If yes, list ages and gender:

_____
_____

Describe your relationship with your children:

_____
_____

Educational History

Highest Grade Completed? _____ Where? _____

If you attended college or graduate school, where and what area of study?

_____

_____

Occupational History

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? ( ) Yes ( ) No. If so, what branch and when?

_____

Honorable discharge? ( ) Yes ( ) No. Other type discharge _____

Legal History

Have you ever been arrested or have any pending legal problems? ( ) Yes ( ) No. If yes, please describe

_____

_____

Spirituality

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No. If yes, what is the level of your involvement? _____ Do you find your involvement helpful during this time, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

_____

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