Terri Allen, M.S., LMHC

(509) 823-0191 (o)
(509) 594-2136 (c)
(509) 343-3356 (f)
Email: terri@fcacyakima.com
Website: www.fcacyakima.com

5803 Englewood Avenue
Yakima, WA 98908-2336
Mon – Thurs, 8:00AM – 5:00PM
By appointment

BEHAVIORAL HEALTH INTAKE QUESTIONNAIRE

PLEASE COMPLETE ALL SECTIONS AND ALL ITEMS

DEMOGRAPHIC AND INSURANCE INFORMATION:

First/Last Name:		Referred by:
DOB:	Age:	Primary Phone:
Street Address: City/State/Zip:		Email:
Insurance Provider:		Subscriber Name: Subscriber's Date of Birth:
Insurance ID#:		Insurance Group#:
This form completed by:		Relationship to client:

IDENTITY INFORMATION (Client's choice to complete)

If assisting another to complete this form, please do not answer on their behalf.

Preferred Pronoun: ☐ She ☐ He ☐ They ☐ Ze ☐ Not listed, please indicate:			
Sexual Orientation:	Gender Identity: Gender Assignment:	Religion or Spiritual Practice:	Race and Ethnicity:

PRESENTING PROBLEM(S):

Please describe the current situations, experiences, or relationships that compelled you to come to counseling now.	
How long have you experienced these problems? How did they start? What's it been like?	
What do you hope will be different after counseling?	

SAFETY CONCERNS:

Do you have thoughts/behaviors of hurting yourself? (cuts, burns, hits)	☐ No ☐ Yes, Explain:
Do you ever have thoughts of hurting other people?	☐ No ☐ Yes, Explain:
Do you ever get frustrated and break things or set fire to objects?	☐ No ☐ Yes, Explain:
How safe do you feel in your life?	☐ Very safe ☐ Fairly safe ☐ Not very safe

BACKGROUND INFORMATION:

Trauma History:

Have you experienced or witnessed a traumatic event?		
Domestic violence?	When?	Please explain:
Abuse/Assault?	When?	Please explain:
Rape/Sexual assault?	When?	Please explain:
Combat trauma?	When?	Please explain:
Suicide?	When?	Please explain:
Bullying?	When?	Please explain:
Other? Specify:	When?	Please explain:

Past Psychiatric History:

Have you been in counseling before? ☐ No ☐ Yes Diagnosis:	With whom? When?

Family Psychiatric History:

Please indicate who in your family has experienced the following concerns:		
	Client	**Family Members, Who?** (mother, father, sister, brother, uncle, aunt, grandparent, etc.)
ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Autism	☐	☐
Learning Disorder	☐	☐
Bipolar Disorder	☐	☐
Schizophrenia	☐	☐
Suicide	-	☐
Other (specify):	☐	☐

Medical Conditions and History:

Doctor:	Date of last exam:	Allergies:
Hospitalizations/Surgeries: When: Why: When: Why:	How have you been sleeping?	
Please indicate any health concerns you may have:		
Emergency contact (name): Address: Phone: Relation to you:		

Current Medications:

Medication:	Dosage:	Reason:
Medication:	Dosage:	Reason:
Medication:	Dosage:	Reason:
Medication:	Dosage:	Reason:

RESOURCES:

Who are the people you turn to for support?	
Do you have adequate access to medical care? If not, explain.	
What do you consider to be your source(s) of internal strength?	
What strategies do you have to self-sooth or calm down?	

Substance Use:

How frequently do you use any of the following substances:

Alcohol:
☐ Never ☐ 2 – 4 times/month ☐ 1 – 3 times/week ☐ 4+ times/week ☐ Daily
☐ How much do you consume at a time?

Tobacco:
☐ Never ☐ 2 – 4 times/month ☐ 1 – 3 times/week ☐ 4+ times/week ☐ Daily
☐ How much do you consume at a time?

Marijuana:
☐ Never ☐ 2 – 4 times/month ☐ 1 – 3 times/week ☐ 4+ times/week ☐ Daily
☐ How much do you consume at a time?

Other drug(s), specify type:
☐ Never ☐ 2 – 4 times/month ☐ 1 – 3 times/week ☐ 4+ times/week ☐ Daily
☐ How much do you consume at a time?

Have you ever received treatment for substance abuse? ☐ Yes ☐ No
If yes, please explain:

Current Family Situation:

Who lives in your home?

Name	Relation to client	Age	How is the client getting along with family members?
			☐Great ☐Good ☐Okay ☐Some conflict ☐Much conflict
			☐Great ☐Good ☐Okay ☐Some conflict ☐Much conflict
			☐Great ☐Good ☐Okay ☐Some conflict ☐Much conflict
			☐Great ☐Good ☐Okay ☐Some conflict ☐Much conflict
			☐Great ☐Good ☐Okay ☐Some conflict ☐Much conflict

Describe any family concerns that you currently have:

Developmental History:

Did you experience any delays in your development? ☐ No ☐ Yes
If yes, explain:

Developmental History (Child Clients):

Concerns during pregnancy: Concerns during delivery: Developmental Concerns:
Age when first walked: Age when started talking: Age when toilet trained:

Family of Origin:

Are your parents: ☐ Married ☐ Divorced		Do you have step parents? ☐ Yes ☐ No
How many siblings do you have?		Where are you in the birth order?
What was your religious upbringing?		What is your earliest memory?
How would you describe your father's parenting style?	☐ Controlling/bossing ☐ Permissive/indulgent ☐ Dismissive/disinterested ☐ Nurturing/caring	
How would you describe the nature of your relationship with your father?		
How would you describe your mother's parenting style	☐ Controlling/bossing ☐ Permissive/indulgent ☐ Dismissive/disinterested ☐ Nurturing/caring	
How would you describe the nature of your relationship with your mother?		
How would you describe the nature of your relationship with your step parent(s)?		

Significant experiences:

Please indicate experiences that, when you bring them to mind, activate difficult emotions. These may be memories from childhood or any part of your life, or they may be recent events.	
1.	Age:
2.	Age:
3.	Age:
4.	Age:
5.	Age:
6.	Age:
7.	Age:
8.	Age:
9.	Age:
10.	Age:

Education History: Are you in school? ☐ No ☐ Yes

School:	Grade:	Do you have an IEP? ☐ No ☐ Yes
If yes, what services are provided?		☐ Reading ☐ Writing ☐ Math ☐ Speech ☐ Occupational Therapy ☐ Behavior ☐ Other:

Work History:

Are you employed? ☐ No ☐ Yes If yes, what is your job?	
How satisfied are you with your job?	
How satisfied are you with your performance?	
Please, mark all that apply to current or former employment: ☐ Military ☐ Law Enforcement ☐ First Responder ☐ Crisis Responder	

Social History:

Who are the people in your social group? What activities do you do together?
What are your interests/hobbies/preferred activities?
How do you think you're getting along with others?

Legal History:

Have you had any arrests or convictions? ☐ No ☐ Yes If yes, when? What were the charges? What was outcome?
Custody hearings? ☐ No ☐ Yes If yes, please elaborate: A copy of the Parenting Plan must be submitted for any client under age 18.
Are you involved in any court proceedings currently? ☐ No ☐ Yes If yes, please provide details:

READINESS - How ready do you think you are for therapy? Mark just one.

- ☐ I don't want to be here. The problem isn't me. It's someone or something else.
- ☐ I think therapy is a good idea.
- ☐ I'm ready for therapy.
- ☐ I'm ready for therapy and eager to get going.

Is there anything else you think it would be helpful for your therapist to know? ________________

____

____

____

____

____

____

____

____

BELIEFS ABOUT YOURSELF

Please mark all of the following that you believe to be true about yourself:	
☐ I'm not good enough.	☐ I'm fine as I am.
☐ I don't deserve love.	☐ I deserve love.
☐ I'm a bad person.	☐ I'm a good person.
☐ I'm stupid	☐ I'm competent.
☐ I'm worthless.	☐ I'm worthy.
☐ I'm shameful.	☐ I'm honorable.
☐ I'm a failure.	☐ I'm a success.
☐ I deserve only bad things.	☐ I deserve good things.
☐ I'm permanently damaged.	☐ I am/can be healthy.
☐ I'm ugly.	☐ I'm fine/attractive.
☐ I'm not important.	☐ I'm significant/important.
☐ I'm a disappointment.	☐ I'm okay just the way I am.
☐ I deserved to die.	☐ I deserve to live
☐ I don't belong.	☐ I belong.
☐ I should have known better.	☐ I do the best I can/I can learn.
☐ I'm inadequate/weak.	☐ I'm adequate/strong.
☐ I can't trust anyone.	☐ I can choose whom to trust.
☐ I'm not safe.	☐ I'm safe now.
☐ It's not okay to show my emotions.	☐ I can safely show my emotions.
☐ I'm not in control.	☐ I am now in control.
☐ I'm helpless/powerless.	☐ I now have choices.
☐ I can't be trusted.	☐ I can be trusted.
☐ I have to be perfect.	☐ I can be myself/make mistakes.
☐ I can't handle it.	☐ I can handle it.

NAME:____________________________ DATE:________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)
Depression Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**Over half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
Total Columns				
Total Score (add column scores)				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

GENERALIZED ANXIETY DISORDER 7- ITEM (GAD-7) SCALE

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Total Columns				
Total Score (add column scores)				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?	☐ Yes ☐ No
2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	☐ Yes ☐ No
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? **or** Try to or actually have oral, anal, or vaginal sex with you?	☐ Yes ☐ No
4. Did you often feel that … No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?	☐ Yes ☐ No
5. Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	☐ Yes ☐ No
6. Were your parents ever separated or divorced?	☐ Yes ☐ No
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? **or** Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? **or** Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	☐ Yes ☐ No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐ Yes ☐ No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	☐ Yes ☐ No
10. Did a household member go to prison?	☐ Yes ☐ No

Now add up your "Yes" answers: _______ This is your ACE Score

PTSD Checklist PCL-C

The next questions are about problems and complaints that people sometimes have in response to stressful life experiences. Please indicate how much you have been bothered by each problem *in the past month*. For these questions, the response options are: “not at all” (1), “a little bit” (2), “moderately” (3), “quite a bit” (4), or “extremely” (5).

PCL1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past **Specify the stressful experience:**	1	2	3	4	5
PCL2	Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
PCL3	Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?	1	2	3	4	5
PCL4	Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL5	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL6	Avoiding thinking or talking about a stressful experience from the past or avoiding having feelings related to it?	1	2	3	4	5
PCL7	Avoided activities or situations because they reminded you of a stressful experience from the past	1	2	3	4	5
PCL8	Having trouble remembering important parts of a stressful experience from the past?	1	2	3	4	5
PCL9	Loss of interest in activities that you used to enjoy?	1	2	3	4	5
PCL10	Feeling distant or cut off from other people?	1	2	3	4	5
PCL11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
PCL12	Feeling as if your future somehow will be cut short?	1	2	3	4	5
PCL13	Having trouble falling or staying asleep?	1	2	3	4	5
PCL14	Feeling irritable or having angry outbursts?	1	2	3	4	5
PCL15	Difficulty concentrating?	1	2	3	4	5
PCL16	Being “super alert” or watchful or on guard?	1	2	3	4	5
PCL17	Feeling jumpy or easily startled?	1	2	3	4	5