Granite City Counseling, LLC
Empathy. Encouragement. Empowerment.

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DATE_____/_____/_____

ADULT CLINICAL INTAKE

IDENTIFYING INFORMATION

Name_____D.O.B._____/_____/_____Age_____
Address_____
City_____ State_____ Zip_____
Home Phone Number _____Cell Phone Number_____
Race:_____
Can we give a reminder call by phone? _____Yes _____No
May we leave a message? _____Yes _____No
Who referred you? _____

Employment Information
Client: Place_____ Phone_____
Spouse: Place_____ Phone_____

It is your responsibility to inform Granite City Counseling of changes in address, phone number and insurance coverage.

In an effort to coordinate care, we would like to obtain/give information from previous providers and /or your referral source. **With your written authorization, we will be informing your physician (by letter) of your diagnosis and care here, communicating (as necessary) with your referring agent and requesting past mental health records.**

Do you wish to sign a release of information for the following?
Physician's Name:_____ ____ Yes ____No
Past Mental Health Agency/Counselor:_____ ____ Yes ____No
Psychiatrist's Name:_____ ____ Yes ____No

REASON AND GOALS FOR THERAPY: _____

_____

CURRENT SYMPTOM CHECKLIST

***Over the last 2 weeks,* how often have you been bothered by any of the following problems?**
0=not at all; 1=several days; 2=more than half the days; 3= nearly every day

Group A

__little interest or pleasure in doing things
__depressed mood/feeling down/hopeless
__trouble falling asleep
__trouble staying asleep
__sleeping too much
__low energy or fatigue
__significant weight loss
__significant weight gain
__feeling bad about yourself, feeling like a failure or have let others down
__trouble concentrating
__indecisiveness
__restlessness/fidgety
__moving or speaking so slowly that other people could have noticed
__thinking you would be better off dead
__having a plan of how to end your life

Check the symptoms, Groups B through M that *you are currently experiencing*:

Group B

__social isolation or withdrawal
feelings of __worthlessness __helplessness or __hopelessness
__feeling guilty about past events
__low self esteem
__self-injurious or harmful behavior (cutting, scratching, burning)
__lack of personal hygiene or grooming
__lack of motivation
__difficulty stopping tears
__severe mood swings
__being unusually irritable

Group C

__aggressive behaviors
__conduct problems
__oppositional behavior

Group D

__sexual dysfunction
__gender identity problems

Group E

__periods of abnormally and persistent elevated, high or irritable mood
__periods of abnormally and persistent increased energy or focus
__periods of very high self esteem
__periods of decreased need for sleep without feeling tired
__more talkative than usual or pressure to keep talking
__racing thoughts
__easily distracted by irrelevant things
__marked increase in activity level
__excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling)

Group F

__panic attacks; frequency_____
Symptoms associated with panic attacks:
__periods of trouble breathing/feeling smothered
__period of feeling faint, dizzy, or unsteady on feet
__periods of heart pounding or rapid heart rate
__periods of trembling or shaking
__periods of sweating
__periods of choking
__periods of nausea or abdominal upset
__feelings of a situation "not being real"
__numbness or tingling sensations
__hot or cold flashes
__periods of chest pain or discomfort
__fear of dying
__fear of going crazy or doing something uncontrolled
__avoiding everyday places for fear of having a panic attack or having to go with others in order to feel comfortable

Group G

__excessive fear of being judged or scrutinized by other people which causes avoidance or panic in everyday situations
__persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list_____

Group H

__recurrent bothersome thoughts, ideas or images which are ignored
__trouble getting "stuck" on certain thoughts, or having the same thought over and over
__excessive or senseless worrying
__compulsive behaviors that must be done because client feels anxious_____
__needing to have things done a certain way or client becomes very upset
__others complain that you do the same thing over and over to an excessive degree (such as cleaning or checking)
__the obsessions are time consuming

Group I

__experienced, witnessed, or learned of an actual or threatened death, serious injury or sexual violence

Traumatic event _____

__flashbacks in which it feels like the trauma is reoccurring
__recurrent and upsetting thoughts of a past traumatic event
__recurrent distressing dreams of a past upsetting event
__intense or ongoing psychological distress to events that resemble the trauma
__intense physical symptoms of panic and fear to events that resemble the trauma
__spending effort avoiding thoughts or feelings associated with a past trauma
__inability to recall an important aspect of a past upsetting event
__persistent avoidance of activities or situations that cause you to remember a past upsetting event
__marked decreased interest in important activities
__feeling detached or distant from others
__feeling numb or restricted in your feelings
__feeling that your future is shortened
__quick startle response
__feeling like you are always watching for bad things to happen

Group J

__restlessness or feeling keyed up or on edge
__being easily fatigued
__difficulty concentrating or mind going blank
__muscle tension
__irritability

Group K

__avoids activities that require sustained mental effort
__trouble sustaining attention or being easily distracted
__lacking attention to detail
__restless, fidgety
__makes decisions impulsively
__difficulty delaying what you want; having to have your needs met immediately
__trouble maintaining an organized work or living area
__difficulty completing projects
__feeling overwhelmed by the tasks of everyday living
__impatient, easily frustrated
__inconsistent work performance
__making comments to other without considering their impact
__frequent traffic violations or near accidents
__hyperactivity
__makes careless mistakes
__is forgetful in daily activities
__often does not follow through on instructions

Group L

__refusal to maintain body weight above a level most people consider healthy
__intense fear of gaining weight or becoming fat even though underweight
__feelings of being fat, even though you are underweight
__recurrent episodes of binge eating large amount of food
__a feeling of lack of control over eating behavior
__engaging in regular activities to purge, such as self-induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise
__persistent over concern with body shape and weight
__overeating __binge eating __emotional eating __trouble eating

Group M

__delusional or bizarre thought (thoughts you know others would think are false)
__seeing objects, shadows or movements that are not real
__hearing sounds or voices which are not real
__seeing things which are not real
__periods of time where your thoughts or speech are not connected or do not make sense to you or others
__severely impaired ability at function at home or at work
__peculiar behaviors
__inappropriate mood for the situation (i.e. laughing at sad events)
__marked lack of initiative
__frequent feelings that someone or something is out to hurt you or discredit you
__periods of extreme irritability, physical or verbal aggression or rage

FUNCTIONAL IMPAIRMENT

The reported symptoms have created difficulty in the following areas:
WORK:
__not difficult __somewhat difficult __very difficult __extremely difficult
TAKING CARE OF THINGS AT HOME:
__not difficult __somewhat difficult __very difficult __extremely difficult
GETTING ALONG WITH OTHERS:
__not difficult __somewhat difficult __very difficult __extremely difficult

FAMILY HISTORY

Family of Origin: (check the statements that apply)
__raised by both biological parents
__raised by adoptive parents
__raised by biological mother and stepfather
__raised by biological father and stepmother
__raised by biological mother
__raised by biological father
__raised by grandparents

Parents' current marital status: (check the statements that apply)
__married to each other
__never married or together
__divorced when client was ___years old
__mother deceased for ___years
***age of client* at mother's death___**
__father deceased for ___years
***age of client* at father's death___**

Describe childhood family experience: (check the statements that apply)
__witnessed abuse toward others in family ____verbal ____physical ____emotional _____sexual
__experienced abuse from others in family ____verbal ____physical ____emotional _____sexual
__deceased family members_____
__number of brothers _____ sisters _____
__number of step brothers_____ number of stepsisters_____
__number of half-brothers_____ number of half-sisters_____
__birth order of client: ___ of ___ siblings
__experienced __physical __sexual __emotional abuse outside family of origin

Mother/father/siblings have experienced the following problems:
alcohol/drug abuse: __mother __father __siblings(s) __grandparent(s)
significant depression: __mother __father __siblings
significant anxiety: __mother __father __siblings
mental illness: __mother __father __siblings
suicide attempt: __mother __father __siblings
anger problems: __mother __father __siblings
jail/prison: __mother __father __siblings
chronic physical illness: __mother __father __siblings

<u>RELATIONSHIP ISSUES</u>
Marital Status: (check the statements that apply)
__not currently in a relationship
__currently in a serious relationship
__engaged_____ months _____years
__married for _____months _____years
__divorced for _____months _____years
__separated for _____months _____years
__divorce in process____ months _____years
__live-in for _____months _____years
__widowed for _____months _____years
__prior marriages (self) ___ prior marriages (partner)_____

Relationship satisfaction:
__very satisfied with relationship
__satisfied with relationship
__somewhat satisfied with relationship
__dissatisfied with relationship
__very dissatisfied with relationship
__physical/verbal/sexually abusive relationship

Children: Please list your biological, adopted and stepchildren:

Name	Age	Living with you
_____	_____	__Y__N
_____	_____	__Y__N
_____	_____	__Y__N
_____	_____	__Y__N
_____	_____	__Y__N
_____	_____	__Y__N

Are there other persons living in your home? _____Yes _____No
If yes, whom? _____

SUBSTANCE USE HISTORY

On the average, how often do you drink alcohol?
___never ___once or twice a year ___once per month ___several times per week ___once per week ___ daily
On the average, how much do you drink per week?
___1-3 drinks ___4-8 drinks ___8 or more drinks

In the last year, have you experienced any of the following?

Picked up or charged with a drug-related driving offense	**Y N DK**
Lost time from school or work because of use	**Y N DK**
Experienced a medical problem because of use	**Y N DK**
Been fired from a job because of use and its effects	**Y N DK**
Felt you ought to cut down on your drinking or drug use	**Y N DK**
Do people annoy you by criticizing your drinking or drug use	**Y N DK**
Felt bad or guilty about your drinking or drug use	**Y N DK**
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover	**Y N DK**

In the last year, have you used mood enhancing nonprescription drugs? __Y __N
Substance use status: (check all that apply)
__no history of abuse
__active abuse
__early full remission
__early partial remission
__sustained full remission
__sustained partial remission

Treatment history:
___outpatient (age(s)____Facility_____Month/Year_____
City/State _____

___inpatient (age(s)____ Facility_____Month/Year_____
City/State _____
___12-step program (age(s)_____
___stopped on own (age(s)_____
___other _____

Check any of the following substances you have ever used:
__alcohol
__amphetamines/speed
__barbiturates/downers
__cocaine
__crack cocaine
__hallucinogens (e.g., LSD/Angel Dust)
__inhalants (e.g., glue, gas)
__marijuana or hashish
__opiates (heroine, morphine)
__ pain pills w/o a prescription
__tranquilizers
__crank
__PCP
__methadone
__other_____

Consequences of substance abuse (check all that apply)

__hangovers	**__withdrawal symptoms**	**__sleep disturbance**	**__binges**
__seizures	**__medical conditions**	**__assaults**	**__job loss**
__blackouts	**__tolerance changes**	**__suicidal impulse**	**__arrests**
__overdose	**__loss of control of amount used**	**__relationship conflicts**	

__other_____

Have you ever received a DWI or DUI? __No __ Yes/When?_____
Nicotine/cigarette use: daily amount _____ Caffeine use: daily amount_____

<u>SOCIO-ECONOMIC HISTORY</u>

Living situation: (check all that apply)	**Financial situation:**
__housing adequate	**__no current financial problems**
__homeless	**__large indebtedness**
__housing overcrowded	**__poverty or below poverty level**
__dependent on others for housing	**__impulsive spending**
__housing dangerous/deteriorating	**__relationship conflicts over finances**

Social support system:
__supportive network
__a few friends
__substance use-based friends
__no friends
__distant from family of origin

Employment:
__employed and satisfied
__employed but dissatisfied
__unemployed
__coworker conflicts
__supervisor conflicts
__unstable work history

Sexual history:
__heterosexual orientation
__homosexual orientation
__bisexual orientation
__currently sexually active
__currently sexually satisfied
__currently sexually dissatisfied
__use of internet porn
__age first pregnancy/fatherhood____
__history of promiscuity age ____to____
__history of unsafe sex age ____to____

Education:
__graduated high school
__graduated college: diploma/degree earned _____
__GED
__attended some college
__learning difficulties: if checked specify_____
Religion:
__religious preference_____
__spiritual beliefs are an important part of your life ____Yes ____No
Legal:
__no legal problems
__now on parole/probation
__arrest(s) not substance related
__arrest(s) substance-related
__court ordered this treatment
__jail/prison_____ time(s)
total time served _____days _____months _____years
describe last legal difficulty_____

Military history:
__never in military
__served in military (dishonorable discharge)
__served in military (honorable discharge)
__still on active duty

EMOTIONAL/PSYCHIATRIC HISTORY

Prior *outpatient* treatment for a psychiatric or emotional disorder

Provider name	**Mo/Yr**	**City/State**

Have you been hospitalized for mental health issues or suicidal thoughts?
___No ___Yes When?_____

Prior *inpatient* treatment for a psychiatric or emotional disorder

Facility name	**Mo/Yr**	**City/State**

MEDICAL HISTORY

Describe your current physical health: __Good __Fair __Poor
List name of primary care physician:
Name: _____Phone:_____

List medications currently being taken:

____None	**_____High blood pressure**	**____Heart pills**
____Insulin	**_____Anti-inflammatory pills**	**____Allergy pills**
____Pain pills	**_____Anticonvulsant pills**	**____Stomach pills**

____Antibiotics
____Tranquilizers
____Other_____
____Anti-psychotic _____ dosage _____ Frequency _____
____Anti-depressant_____ dosage_____ Frequency _____
____Anti-anxiety_____ dosage_____ Frequency _____

List any known allergies: _____

Describe any serious hospitalization or accidents:
Date_____ Age _____ Reason_____
Date_____ Age _____ Reason_____
Past medical problems/conditions: _____
Current medical problems/conditions: _____
Do you have a history of any of the following?
__history of head trauma ____seizures/seizure-like activity
Do you exercise regularly ____No ____Yes

STRENGTHS

Check any of the following that apply:

__Accepts Guidance and Feedback	**__Clear Thinking**
__Motivated for Change	**__Confident**
__Physically Healthy	**__Expressive/Articulate**
__Positive Support Network	**__Good Personal Care Habits**
__Reasonable Judgment	**__Insightful**
__Reliable	**__Integrated Moral Values**
__Responsible	**__Intelligent**
__Sociable	**__Good Work Ethic**
__Stable Living Environment	**__Caring**
__Stable Work History	**__Organized**
__Supportive Family	**__Good Communicator**
__Capable of Independence	**__Funny**

__Varied Interests

PRECIPITATING FACTORS AND LIFE STRESSORS

Are you experiencing significant changes, loss or difficulties in the following areas?

__Economic Stress
__Educational Deficit
__Family Conflict
__Health Concerns
__Inadequate Housing
__Legal Conflicts
__Occupational Problems
__Relationship Conflict
__Social/Environmental Problems
__Limited Support Network
__Grief and Loss
__Stress of Single Parenting