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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

### RELATIONSHIP ISSUES

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

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 (heroin, 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 \_\_\_\_\_

**SOCIO-ECONOMIC HISTORY**

**Living situation: (check all that apply)**

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating

**Financial situation:**

- no current financial problems
- large indebtedness
- poverty or below poverty level
- impulsive spending
- 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
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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
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**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?

- |  |  |
|--|--|
| <input type="checkbox"/> Economic Stress     | <input type="checkbox"/> Occupational Problems         |
| <input type="checkbox"/> Educational Deficit | <input type="checkbox"/> Relationship Conflict         |
| <input type="checkbox"/> Family Conflict     | <input type="checkbox"/> Social/Environmental Problems |
| <input type="checkbox"/> Health Concerns     | <input type="checkbox"/> Limited Support Network       |
| <input type="checkbox"/> Inadequate Housing  | <input type="checkbox"/> Grief and Loss                |
| <input type="checkbox"/> Legal Conflicts     | <input type="checkbox"/> Stress of Single Parenting    |