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**Inclusivity Clinical Consulting Services**

ICCS, 609 Deep Valley Drive, Suite 200, Rolling Hills Estates, CA 90274, USA 310.594.9605 info@inclusivityconsulting.com Website: http://inclusivityconsulting.com/

Intake Data Form:

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEMOGRAPHIC INFORMATION:**

Age: \_\_\_\_\_\_\_

1. Gender identity

\_\_ Female \_\_ Male \_\_ Transgender \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Ethnic identity

\_\_ African American \_\_ Asian \_\_ Hispanic/Latino \_\_ White \_\_ Biracial/multiracial

\_\_ Native American \_\_ Hawaiian/Pacific Islander \_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Language Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language(s) Spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Self-Identified sexual orientation

\_\_Heterosexual/straight \_\_Lesbian \_\_Gay \_\_Bisexual \_\_Questioning/Queer/other

1. Relationship status

\_\_ Single \_\_ Married/committed partnership \_\_Separated/Divorced \_\_ Widowed

1. Current employment status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Highest level of education

\_\_ Some high school \_\_ High school graduate or GED \_\_ Vocational training \_\_ 2-year college \_\_ 4-year college \_\_ Graduate or professional school

**SOCIAL HISTORY:**

1. Current pending legal issues \_\_ Yes \_\_ No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List family/relatives who have lived with mental health issues such as depression or anxiety?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List family/relatives who have lived with substance abuse (alcohol or drugs):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have supportive family members (family of origin and/or family of choice) or significant relationship? \_\_ Yes \_\_ No

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you prefer for anyone to participate in your care at ICCS? \_\_ Yes \_\_ No

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have religious/spiritual or cultural concerns (ethnic, gender, disability, sexual orientation, etc.) that might influence treatment, such as preferences, experiences of discrimination, or cultural beliefs about mental health, etc.? \_\_ Yes \_\_ No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How important is religion/spirituality in your life?

\_\_ Not at all \_\_ Slightly \_\_ Moderately \_\_ Quite a bit \_\_ Extremely

**PHYSICAL HEALTH AND PAIN:**

1. In general, how do you rate your physical health?

\_\_ Poor \_\_ Fair \_\_ Good \_\_ Very Good \_\_ Excellent

1. During the past three months, how much physical pain would you report on a scale form 1 (no pain) to 10 (intolerable pain)? \_\_\_\_\_\_\_\_
2. During the past three months, how much did pain interfere with your usual activities?

\_\_ Not at all \_\_ Slightly \_\_ Moderately \_\_ Quite a bit \_\_ Extremely

1. Have you seen your primary care provider within the last year? \_\_ Yes \_\_ No
2. List medical conditions

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List all prescription and non-prescription (over-the-counter medications) you take regularly:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List all supplements and vitamins you take regularly:

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1. Please list any allergies to food or medicine:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REPRODUCTIVE/SEXUAL HEALTH:**

1. Are you currently sexually active? \_\_ Yes \_\_ No
2. If you sexually active, are you practicing safer sex, such as using condoms or dental dams? \_\_ Yes \_\_ No
3. Do you have any past or current sexually transmitted infections (STIs)? \_\_ Yes \_\_ No
4. How many children do you have, if any? \_\_\_\_\_\_\_
5. Please list any fertility concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. How would you describe your sexual satisfaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How do any of your physical or mental health conditions influence your sex life?

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**WOMEN ONLY - REPRODUCTIVE/SEXUAL HEALTH:**

1. Are you planning to get pregnant or is it possible you will get pregnant? \_\_ Yes \_\_ No
2. Are you currently pregnant? \_\_ Yes \_\_ No
3. How many miscarriages/stillborn/infant losses have you had, if any? \_\_\_\_\_\_
4. Do you have a history of post-partum mental health issues such as depression or anxiety? \_\_ Yes \_\_ No
5. If you are of reproductive age and have a male partner, are you using birth control? \_\_ Yes \_\_ No
6. If you are of reproductive age, do you have regular menstrual cycles (periods)? \_\_ Yes \_\_ No
7. Do PMS symptoms (pre-menstrual syndrome) significantly impact your mental health? \_\_ Yes \_\_ No
8. Are you bothered by menopause-related symptoms such as hot flashes, irritability, or impaired sleep? \_\_ Yes \_\_ No

**SOCIAL AND MENTAL HEALTH HISTORY:**

1. Have you had any previous mental health treatment (group, individual, or family therapy) before? If so, please describe and note what was helpful and what was not:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have you ever taken medications to help you with mental health symptoms (depression, anxiety, ADHD, etc.)? If so, please describe:

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1. Have you ever been hospitalized for a mental health issue (depression, suicide, etc.)? \_\_ Yes \_\_ No
	1. If yes, please list approximate dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If yes, was it voluntary or involuntary? \_\_ Voluntary \_\_ Involuntary
2. Please list any significant events in your childhood (parental divorce, moves, accidents, bereavement issues, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please summarize your adult romantic relationship history (e.g. number and quality of them):

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1. Do you have any current significant issues with family, friends, or partners?

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**INTIMATE PARTNER VIOLENCE SCREEN:**

1. Has a partner physically hurt you within the last 12 months?

\_\_ Never \_\_ Rarely \_\_ Sometimes \_\_ Often \_\_ Frequently

1. Has a partner insulted or hurt you within the last 12 months?

\_\_ Never \_\_ Rarely \_\_ Sometimes \_\_ Often \_\_ Frequently

1. Has a partner threatened to hurt you within the last 12 months?

\_\_ Never \_\_ Rarely \_\_ Sometimes \_\_ Often \_\_ Frequently

1. Has a partner physically screamed or cursed at you within the last 12 months?

\_\_ Never \_\_ Rarely \_\_ Sometimes \_\_ Often \_\_ Frequently

1. Has a partner physically forced you to have sexual activities within the last 12 months?

\_\_ Never \_\_ Rarely \_\_ Sometimes \_\_ Often \_\_ Frequently

1. Have any of these things happened to you more than a year ago? \_\_ Yes \_\_ No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER TRAUMA HISTORY:**

1. \_\_ Yes \_\_ No Do you have a history of childhood sexual trauma?
2. \_\_ Yes \_\_ No Do you have a history of childhood physical abuse?
3. \_\_ Yes \_\_ No Do you have a history of childhood neglect or emotional abuse?
4. \_\_ Yes \_\_ No Do you have a history of adult (non-military) sexual trauma?
5. \_\_ Yes \_\_ No Do you have a history of being the victim of other types of violence?
6. \_\_ Yes \_\_ No Have you been in a natural disaster or significant accident?

**BEHAVIORAL HEALTH:**

55. \_\_ Yes \_\_ No Do you drink caffeine such as coffee/soda/energy drinks? If so, how many cups/day\_\_\_\_

1. \_\_ Yes \_\_ No Do you need help in activities of daily living (getting showered, dressed, and fed)?
2. \_\_ Yes \_\_ No Do you eat large amounts of food and feel like you cannot stop?
3. \_\_ Yes \_\_ No Do you make yourself throw up, take laxatives, or excessively exercise to make up for taking in calories?
4. \_\_ Yes \_\_ No Have you engaged in extreme dieting or starvation (restricting)?
5. \_\_ Yes \_\_ No Do you have concerns about the way you feel about your body (body image)?
6. \_\_ Yes \_\_ No Have you lost 10 pounds within the last 6 months without wanting to?
7. \_\_ Yes \_\_ No Have you gained 10 pounds with the last 6 months without wanting to?
8. \_\_ Yes \_\_ No Have you changed the kind or amount of food you eat due to any illness?

**SUBSTANCE ABUSE:**

1. \_\_ Yes \_\_ No Do you currently drink alcohol? If so, how much/ how often? \_\_\_\_\_\_\_\_\_\_\_
2. \_\_ Yes \_\_ No Do you have a history of problematic alcohol use?

 \_\_ Yes \_\_ No Have you ever felt you should cut down on your drinking?

 \_\_ Yes \_\_ No Have people annoyed you by criticizing your drinking?

 \_\_ Yes \_\_ No Have you ever felt bad or guilty about your drinking?

 \_\_ Yes \_\_ No Have you ever had a drink first thing in the morning to steady your nerves and get rid of a hangover?

1. \_\_ Yes \_\_ No Do you currently use drugs? If so what, and how often? \_\_\_\_\_\_\_\_\_\_\_
2. \_\_ Yes \_\_ No Do you have a history of drug use?

If so, what was used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered yes to the above questions, please describe the age of first use, your typical pattern of use, and how long you have been clean/sober?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. \_\_ Yes \_\_ No Do you have a relapse history?

 Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_ Yes \_\_ No Do you have a current support system for sobriety?

 Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_ Yes \_\_ Any legal, physical, or social problems associated with your substance use?

 Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_ Yes \_\_ Do you currently smoke cigarettes, cigars, or pipe? If so, how many packs/day\_\_\_\_\_\_\_
2. \_\_ Yes \_\_ Do you have a history of nicotine use?

 If so, how long since pt quit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RISK FACTORS:**

1. \_\_ Yes \_\_ No Have you recently engaged in self- harm, cutting, pinching, or being reckless?

 Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_ Yes \_\_ No Do you have a history of self- harm, cutting, pinching, reckless or impulsive acts?

 Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_ Yes \_\_ No Do you have a history of suicidal acts (attempts or steps made to prepare for an attempt) or thoughts?

 Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

75. \_\_ Yes \_\_ No Do you have current thoughts of suicide?

 \_\_ Yes \_\_ No Plan? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_ Yes \_\_ No Intention? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Yes \_\_ No Means? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

76. \_\_ Yes \_\_ No Do you have current thoughts of harming someone else or someone else’s property?

 \_\_ Yes \_\_ No Plan? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_ Yes \_\_ No Intention? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Yes \_\_ No Means? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROTECTIVE FACTORS:**

77. Yes \_\_ No Do you have social supports? (friends, family, or someone to help?)

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

78. Yes \_\_ No Do you have hobbies or leisure time interest/activities?

 If so, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

79. Yes \_\_ No Do you have a pet?

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are some of your strengths that can benefit you while in treatment?**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**GOALS FOR TREATMENT:**

Please list three goals for seeking psychotherapy?

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**GOALS FOR LIFE:**

Please list your short term and long term personal goals.

Short Term\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Long Term\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SELF-REPORT SYMPTOM RATINGS:** Please **circle** the number that best describes how you feel.

**A. How Sad/Depressed you have been feeling in the past week?**

 **1**-------2-------3-------4-------**5**-------6-------7-------8-------9-------**10**

Not at all Feeling sad but Extremely functioning depressed

**B. What is your average level of Anxiety in the past week?**

 **1**-------2-------3-------4-------**5**-------6-------7-------8-------9-------**10**

 Not at all Anxious but Extremely tense

 able to function (avoiding activities)

**C. What is your average Quality of Sleep in the past week?**

 **1**-------2-------3-------4-------**5**-------6-------7-------8-------9-------**10**

Little to no sleep Moderate Excellent, sound sleep, no interruptions

**D. What is your overall Well-Being in the past week?**

 **1**-------2-------3-------4-------**5**-------6-------7-------8-------9-------**10**

 I feel terrible. Neither good/bad or a I feel great.

 mixture of both