

INTAKE FORM

Please provide the following information and answer the questions below.

Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male Female

Marital Status:

- Never Married Married
 Separated Divorced Widowed

On a scale of 1-10, how would you rate your relationship? _____

Please list all people living in household:

| <i>Name</i> | <i>Relationship to Child</i> | <i>Age</i> |
|-------------|------------------------------|------------|
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

Address:

(City) (State) (Zip)

Home Phone:

May we leave a message? Yes No

Cell/Other Phone:

May we leave a message? Yes No

E-mail:

May we email you? Yes No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

How did you find out about Compassionate Counseling Services?

Presenting Problem:

Briefly describe your current difficulties:

How long has this been a concern for you? _____

When this problem was first noticed? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes, previous therapist/practitioner and date of last service:

Are you currently taking any prescription medication?

- No
- Yes. Please list.

Have you ever been prescribed psychiatric medication?

- No
- Yes. Please list and provide dates.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in?

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief, or depression?

No

Yes

If yes, for approximately how long?

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

No

Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe:

8. Do you drink alcohol more than once a week? No Yes

9. How often do you engage recreational drug use?

Daily

Weekly

Monthly

Infrequently

Never

10. Have you ever experienced physical abuse? No Yes
If yes, at what age?

11. Have you ever experienced sexual abuse? No Yes
If yes, at what age?

12. What significant life changes or stressful events have you experienced recently?

13: Have you ever had legal problems involving the court system or law enforcement? No Yes
If yes, Please explain:

14. What is your highest degree of education completed? Please list date of completion and from what school.

15. Have you experienced the death of someone close to you? No Yes
If yes, please describe.

16. Have you ever been hospitalized for mental health concerns? No Yes
If yes, please explain with date and place.

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? No Yes
If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

| | Not at all | Several days | More than 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 |

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

| | |
|--|--|
| <p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p> | <p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p> |
|--|--|

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 sure | 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 |
| <i>Add the score for each column</i> | + | + | + | |
| Total Score (<i>add your column scores</i>) = | | | | |

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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Name _____ Date _____

Alcohol and Substance Abuse Screening Tool- C.A.G.E.

1. Have you ever felt you should *cut* down on your drinking or substance use (prescription or non-prescription)?

Yes No

2. Have people *annoyed* you by criticizing your drinking or substance use?

Yes No

3. Have you ever felt bad or *guilty* about your drinking or substance use?

Yes No

4. Have you ever had a drink or used substances first thing in the morning to steady your nerves or get rid of a hangover (*eye-opener*)?

Yes No

Comments:

Tobacco Screening Tool

1. Do you currently use tobacco? Yes No

If Yes, check all that apply: Cigarettes Cigars Pipe Chewing Tobacco

2. If yes, how interested are you in cutting down or stopping your tobacco use?

Very Somewhat Not at this time

3. Are you interested in information regarding options?

Yes No

For Office Use Only:

Date of Screen: _____

Information provided by CCS:

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

36-item version, self-administered

Patient Name: _____ Age: _____ Sex: Male Female Date: _____

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include **diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs**. Think back over the **past 30 days** and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only **one** response.

| Numeric scores assigned to each of the items: | | | | | | | <i>Clinician Use Only</i> | | | | | | | |
|---|---|------|------|----------|--------|----------------------|---------------------------|---|---|---|----|----------------|------------------|----------------------|
| | | | | | | | 1 | 2 | 3 | 4 | 5 | Raw Item Score | Raw Domain Score | Average Domain Score |
| In the <u>last 30 days</u> , how much difficulty did you have in: | | | | | | | | | | | | | | |
| Understanding and communicating | | | | | | | | | | | | | | |
| D1.1 | Concentrating on doing something for <u>ten minutes</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | 30 | 5 | |
| D1.2 | Remembering to do <u>important things</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D1.3 | Analyzing and finding solutions to problems in day-to-day life? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D1.4 | Learning a <u>new task</u> , for example, learning how to get to a new place? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D1.5 | Generally understanding what people say? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D1.6 | Starting and maintaining a <u>conversation</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| Getting around | | | | | | | | | | | | | | |
| D2.1 | Standing for <u>long periods</u> , such as <u>30 minutes</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | 25 | 5 | | |
| D2.2 | Standing up from sitting down? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D2.3 | Moving around <u>inside your home</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D2.4 | Getting out of your home? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D2.5 | Walking a <u>long distance</u> , such as a kilometer (or equivalent)? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| Self-care | | | | | | | | | | | | | | |
| D3.1 | Washing your <u>whole body</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | 20 | 5 | | |
| D3.2 | Getting <u>dressed</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D3.3 | Eating? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D3.4 | Staying <u>by yourself</u> for a <u>few days</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| Getting along with people | | | | | | | | | | | | | | |
| D4.1 | Dealing with people you do not know? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | 25 | 5 | | |
| D4.2 | Maintaining a friendship? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D4.3 | Getting along with people who are <u>close to you</u> ? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D4.4 | Making new friends? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |
| D4.5 | <u>Sexual</u> activities? | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | | | | |

| Numeric scores assigned to each of the items: | | | | | | | Clinician Use Only | | | | | | | | | |
|--|---|--|--|--|--|--|--------------------|------|----------|--------|----------------------|----------------|------------------|----------------------|--|--|
| | | | | | | | 1 | 2 | 3 | 4 | 5 | Raw Item Score | Raw Domain Score | Average Domain Score | | |
| In the <u>last 30 days</u> , how much difficulty did you have in: | | | | | | | | | | | | | | | | |
| Life activities—Household | | | | | | | | | | | | | | | | |
| D5.1 | Taking care of your <u>household responsibilities</u> ? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | 20 | 5 | | |
| D5.2 | Doing most important household tasks <u>well</u> ? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D5.3 | Getting all of the household work <u>done</u> that you needed to do? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D5.4 | Getting your household work done as <u>quickly</u> as needed? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| Life activities—School/Work | | | | | | | | | | | | | | | | |
| If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1. | | | | | | | | | | | | | | | | |
| Because of your health condition, in the past <u>30 days</u> , how much <u>difficulty</u> did you have in: | | | | | | | | | | | | | | | | |
| D5.5 | Your day-to-day <u>work/school</u> ? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | 20 | 5 | | |
| D5.6 | Doing your most important work/school tasks <u>well</u> ? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D5.7 | Getting all of the work <u>done</u> that you need to do? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D5.8 | Getting your work done as <u>quickly</u> as needed? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| Participation in society | | | | | | | | | | | | | | | | |
| In the past <u>30 days</u> : | | | | | | | | | | | | | | | | |
| D6.1 | How much of a problem did you have in <u>joining in community activities</u> (for example, festivities, religious, or other activities) in the same way as anyone else can? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | 40 | 5 | | |
| D6.2 | How much of a problem did you have because of <u>barriers or hindrances</u> around you? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D6.3 | How much of a problem did you have <u>living with dignity</u> because of the attitudes and actions of others? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D6.4 | How much <u>time</u> did <u>you</u> spend on your health condition or its consequences? | | | | | | None | Some | Moderate | A Lot | Extreme or cannot do | | | | | |
| D6.5 | How much have <u>you</u> been <u>emotionally affected</u> by your health condition? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D6.6 | How much has your health been a <u>drain on the financial resources</u> of you or your family? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D6.7 | How much of a problem did your <u>family</u> have because of your health problems? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| D6.8 | How much of a problem did you have in doing things <u>by yourself</u> for <u>relaxation or pleasure</u> ? | | | | | | None | Mild | Moderate | Severe | Extreme or cannot do | | | | | |
| General Disability Score (Total): | | | | | | | | | | | 180 | 5 | | | | |

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