Get Out of Your Head Therapy

Psychotherapy & Counseling Service for Children, Adolescents and Adults
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ADULT INTAKE QUESTIONAIRE FORM

Counseling I am seeking: ☐Individual ☐Couple ☐Family ☐Group/Workshop
Office Location: ☐Austin ☐Waco

CLIENT INFORMATION

Date of Birth: ____/_____/_____
Name: _____
Address: _____
_____
City: _____Zip: _____
Cell #_____
Alternate #_____
Email_____
On what number may we leave confidential voicemails?
☐Cell ☐Alternate
Have you ever participated in counseling? ☐yes ☐no
How did you hear about us? _____

EMPLOYER

☐I am employed
☐I am unemployed
☐I am self-employed
☐I am retired
Occupation:_____
Employer: _____

EDUCATION

☐Full-Time Student
☐Part-Time Student
☐Recently Graduated
☐Recently Withdrew/Dropped
Highest Grade/Degree:_____

FAMILY INFORMATION

☐Single
☐Married
☐In a relationship/partnership
☐Never Married
☐Previously married/divorced
☐Separated (still married)
☐Widowed
How many people reside in the home? _____
Name & Relationship:_____
Name & Relationship:_____
Name & Relationship:_____
Name & Relationship:_____
Name & Relationship:_____

HEALTH CARE INFORMATION

Primary Care:_____
Phone:_____

Psychiatrist:_____
Phone:_____

Medication List/Major Health Issues:
_____
_____

EMERGENCY CONTACT

Name:_____
Relationship:_____
Phone #:_____

Why did you decide to seek counseling services?
_____
_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	○	○	○	○	○	
	2. Feeling down, depressed, or hopeless?	○	○	○	○	○	
II.	3. Feeling more irritated, grouchy, or angry than usual?	○	○	○	○	○	
III.	4. Sleeping less than usual, but still have a lot of energy?	○	○	○	○	○	
	5. Starting lots more projects than usual or doing more risky things than usual?	○	○	○	○	○	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	○	○	○	○	○	
	7. Feeling panic or being frightened?	○	○	○	○	○	
	8. Avoiding situations that make you anxious?	○	○	○	○	○	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	○	○	○	○	○	
	10. Feeling that your illnesses are not being taken seriously enough?	○	○	○	○	○	
VI.	11. Thoughts of actually hurting yourself?	○	○	○	○	○	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	○	○	○	○	○	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	○	○	○	○	○	
VIII.	14. Problems with sleep that affected your sleep quality over all?	○	○	○	○	○	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	○	○	○	○	○	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	○	○	○	○	○	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	○	○	○	○	○	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	○	○	○	○	○	
XII.	19. Not knowing who you really are or what you want out of life?	○	○	○	○	○	
	20. Not feeling close to other people or enjoying your relationships with them?	○	○	○	○	○	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	○	○	○	○	○	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	○	○	○	○	○	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	○	○	○	○	○	

SYMPTOM ASSESSMENT

Please give as accurate of an account as you can. If you have any questions or concerns, please feel welcomed to discuss them with your counselor.

I AM EXPERIENCING…	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING…	Never	Seldom	Often	Always	For how long?
Decreased interest in pleasurable activities					
Social Isolation or feelings of loneliness					
Suicidal thoughts					
Bereavement or feelings of loss					
Changes in sleep (too much or not enough)					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE…	Never	Seldom	Often	Always	For how long?
I am angry, irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative than usual					
My moods fluctuate (go up and down)					
Normal, daily tasks require more effort					
Decreased interest in pleasurable activities					

I HAVE…	Never	Seldom	Often	Always	For how long?
Concerns about my sexual function					
Discomfort with engaging in sexual activity					
Questions about my sexual orientation					

I HAVE…	Never	Seldom	Often	Always	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE…	Never	Seldom	Often	Always	For how long?
A desire to engage in behaviors I know are risky					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward others					

I USE THE FOLLOWING…	Never	Seldom	Often	Always	For how long?
Alcohol					
Nicotine (Vaporizers or tobacco products)					
Marijuana					
Cocaine					
Opiates (Codeine, Methadone, Heroin)					
Sedatives (Quaaludes, Xanax, Valium, Benzos)					
Hallucinogens (PCP, LSD, Shrooms, Ecstasy)					
Stimulants (Adderall, Concerta, Vyvanse)					
Methamphetamines					

MY EATING INVOLVES…	Never	Seldom	Often	Always	For how long?
Restriction of food consumption					
Bingeing and purging					
Binge eating					
A lot of weight loss or gain					

EMPLOYMENT & SELF-CARE	Never	Seldom	Often	Always	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I have debt issues that are concerning to me					
I am afraid of becoming homeless					
I have problems accessing healthcare					

PERSONAL & FAMILY HISTORY

Have you ever been hospitalized for a psychiatric illness?	☐YES ☐NO
Have you ever thought about suicide, had a plan or attempted suicide?	☐YES ☐NO
Do you have a history of sexual abuse?	☐YES ☐NO
Do you have a history of physical abuse?	☐YES ☐NO
Have you ever been arrested?	☐YES ☐NO
Has a close relative ever been hospitalized for a psychiatric illness?	☐YES ☐NO
Does anyone in your family have a mental illness?	☐YES ☐NO
Has anyone in your family every attempted or committed suicide?	☐YES ☐NO
Does anyone in your family have a substance abuse problem?	☐YES ☐NO

How well are you doing in your job?

☐1	☐2	☐3	☐4	☐5	☐6
Not Working	Can't Function	Serious Problems	Moderate Problems	Mild Problems	No Problems

How well are you doing in your marital/significant other relationship?

☐1	☐2	☐3	☐4	☐5	☐6
N/A	Can't Function	Serious Problems	Moderate Problems	Mild Problems	No Problems

How well are you doing in your family relationships?

☐1	☐2	☐3	☐4	☐5	☐6
N/A	Can't Function	Serious Problems	Moderate Problems	Mild Problems	No Problems

How well are you doing in relationships with people outside your family?

☐1	☐2	☐3	☐4	☐5	☐6
N/A	Can't Function	Serious Problems	Moderate Problems	Mild Problems	No Problems

Please rate your current physical health?

☐1	☐2	☐3	☐4	☐5	☐6
Very Poor					Excellent

Please rate your general happiness and well-being?

☐1	☐2	☐3	☐4	☐5	☐6
Very Poor					Excellent

What do you like to do for fun? _____

What do you consider to be your greatest strengths? _____