Mental Health Services Intake Questionnaire

EMERGENCY RESPONDERS HEALTH CENTER

Today's Date: _____/_____/_____ ☐ **Female** ☐ **Male**

Legal Name: First: ___________________________ Middle Initial: _______ Last: ___________________________

Preferred First Name: ______________________________ **Birth Date:** _____/_____/_____ **Age:** _______

Contact Info: Phone: ( ) ______-__________ ☐ Cell ☐ Landline Email Address: ______________________________

Profession: ☐ Fire ☐ Law Enforcement ☐ EMS ☐ Emergency Dispatch ☐ Other: _________________
(Note Profession)

○ Military Service: ____
(Note active duty, reserve, or veteran, and branch of service.)

***IF* <u>First Responder</u>:** ☐ Active-Duty Responder ☐ Chief/Deputy Chief ☐ Administrator ☐ Retired

Current Employer: ____ **Since:** _____/_____
MM YY

Social History

Relationship Status: ○ Single/Dating ○ Partnered/Married ○ Separated/Divorced ○ Widowed

Name of Spouse/Significant Other: _____________________________ Years in this Relationship: _______

How would you describe this relationship? ____

____

Parenting Status: ○ Minor Child(ren) (under 18 years) ○ Adult Child(ren) ○ Departed Child(ren) ○ No Children

(Check all that apply.) ○ Stepchildren/Blended Family Comments: ____________________________________

Support Network:

How would you describe your family and social support system?

____

____

____

Cultural/Religious Background:

Please describe other considerations related to your faith or culture you would like your therapist to know:

____

____

____

Reason for Seeking Care ____

Which services are you interested in at this time?

☐ Individual Counseling ☐ Couple's Counseling with: ____________________ ☐ Mental Health Check-Up
(List partner's full name.)*

☐ Workers' Compensation Evaluation for PTSI ☐ Other Support: ____________________________________

**Your partner will also be asked to complete an individual intake form.*

What concerns are you seeking support to help manage? ____

____

When did these concerns begin to trouble you? ____

Which of the following are you currently experiencing? *(Check all that apply.)*

- ☐ Low/Depressed Mood
- ☐ Feeling Isolated/Disconnected
- ☐ Feeling Worthless/Low Self-Esteem
- ☐ Social Withdrawal
- ☐ Loss of Interest in Activities
- ☐ Poor Appetite
- ☐ Mood Swings
- ☐ Irritability/Agitation
- ☐ Feeling Anger/Rage
- ☐ Feeling Aggressive/Aggressive Behaviors
- ☐ Low Sense of Motivation
- ☐ Fatigue/Low Energy
- ☐ Unusual Weight Loss/Gain
- ☐ Binge Eating/Over-Eating
- ☐ Purging/Forced Vomiting
- ☐ Avoiding Eating
- ☐ Poor Body Image
- ☐ Frequent/Chronic Pain
- ☐ Memory Lapses/Forgetfulness
- ☐ Absentmindedness/Misplacing Things
- ☐ Feeling Disconnected Mentally
- ☐ Hyperactivity/Restlessness
- ☐ Inability to Focus/Concentrate
- ☐ Racing Thoughts
- ☐ Decreased Need for Sleep/ Manic Behavior
- ☐ Increased Need for Sleep/ Oversleeping
- ☐ Insomnia/Other Sleep Issues
- ☐ High Levels of Chronic Stress
- ☐ Excessive Worry
- ☐ Persistent Anxiety
- ☐ Anxiety in Social Situations
- ☐ Recurrent Fears/Phobias
- ☐ Feeling Mistrustful
- ☐ Feeling Unsafe
- ☐ Panic Attacks
- ☐ Easily Startled/Hypervigilant
- ☐ Reliving Past Traumatic Events
- ☐ Nightmares/Flashbacks
- ☐ Unwanted Thoughts
- ☐ Obsessive Thoughts/Behaviors
- ☐ Compulsive (uncontrollable) Thoughts/Behaviors
- ☐ Self-Destructive Behaviors
- ☐ Difficulty Forming/Keeping Relationships
- ☐ Fear of Abandonment/Loss
- ☐ Thoughts of Self-Harm
- ☐ Thoughts of Suicide
- ☐ Thoughts of Violence/Homicide

Are you currently experiencing: ○ Relationship/Family Issues ○ Parenting Issues ○ Grief/Loss ○ Job-Related Issues ○ Financial Issues ○ Legal/Custody Issues ○ Abuse/Victimization ○ Harassment ○ Survivor of Violence/Assault ○ Sexual Issues ○ Sexuality/LGBT Issues

If you indicated "yes" to any of the items above, please briefly describe:

____

Do you experience hallucinations? *If yes, please describe.*

____

Do you experience delusional thoughts? *If yes, please describe.*

____

Have you experienced suicidal thoughts or attempts? ○ Yes, recently ○ Yes, in the past ○ Never

If you indicated "yes," please briefly describe:

____

Medical & Mental Health History

Do you use alcohol and drugs? ○ Routinely ○ Often ○ Rarely ○ Never

If "Routinely" or "Often," please provide more details below.

What types of alcohol or drugs do you use? ____

How much of these substances do you use at one time? ______________________________________

How often do you use these substances? ___________ When did you last use these substances? ___________

Substance Abuse Support/Treatment: *If you have undergone previous treatment for alcohol or drug abuse, including support group attendance, outpatient programs, or inpatient admissions, please list them below.*

Group/Program/Facility	Dates	Group/Program/Facility	Dates
______________________________	________	______________________________	________
______________________________	________	______________________________	________

Have you experienced or witnessed a highly traumatic event? ○ Yes, recently ○ Yes, in the past ○ Never

If yes, please briefly provide any information you are comfortable sharing below. You will have the opportunity to describe your experience to your therapist in more detail, when you are comfortable doing so.

____

____

____

MEDICAL CONCERNS: Please list any significant past or current issues.

____

____

____

FAMILY HISTORY: Please note any family history of significant medical issues, mental health or addiction issues, or suicide attempts.

____

____

____

Primary Care Provider: Name: ___________________________________ Phone: (   ) ______-__________

Personal Goals

What are your personal strengths? ____

What do you do to cope with difficult situations? ____

____

What do you hope to gain from counseling? ____

____

Is there anything else you would like for your therapist to know? ______________________________