Grand Blanc Therapy

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Intake Information Questionnaire and Coordination of Care Consent Form

Please fill out ***one*** questionnaire for each member of your family presenting for therapy.

Your cooperation in completing this form will help plan the best services for you. Please answer each item carefully, if you do not understand any item, please ask for help.

Name: _____ Today's Date: _____/_____/_____

Address: _____City+Zip: _____ _____

Email Address:_____ Is it okay to contact you via email? Y or N

Telephone Number(s): _____(H) _____(Cell)

Which number can I leave a message at? Home Cell

Date of Birth: _____/_____/_____ Cash/Type of Insurance: _____

Please Note: if you cancel your appointment on the same day you will be assessed a $120 fee

Gender Identification: Male Female Trans Other: _____ Sexual Orientation: _____

Are you actively/currently suicidal? No **YES**

Have you ever *contemplated* **suicide?** No **Yes…**If **yes,** when (years, your ages)?_____

Have you ever *attempted* **suicide?** No **Yes…..**If **yes,** when and by what means?_____

Trauma History

(please note any traumatic events: abuse/neglect that occurred in your family/lifetime. Trauma can be both objective and subjective; if you believed it was a trauma−I would like to know about it. Traumatic events often result in shame. Internalized shame−from childhood−can often be carried into adulthood and can result in symptoms resulting in impaired functioning (e.g., health, occupational, academic, social, interpersonal).

Type	*Description*	*Your Age/Year of Event*
Physical:		
Emotional:		
Verbal:		
Sexual:		
Medical:		
Criminal:		

******Please write in the space below about any "shame producing events" (e.g., bullying) you have experienced during your lifetime: _____

Coordination of Care with Health Care Providers

I believe in coordinating care with your health care providers, this represents best practice for mental health care providers such as myself. If you give your consent−to coordinate care with your health care provider−I will send a letter to him/her informing that provider of your seeking treatment with me. If your signature appears in this section I will coordinate care with your health care provider. It will be valid for one year, or until you give me written documentation you want to withdraw permission.

Primary Health Care Provider: _____

Address, City + Zip:_____

Psychiatrist:_____

Address, City + Zip: _____

By Signing below,* I consent to coordination of care with my health care provider.

*_____ _____/_____/_____

Signature of client*−purpose: coordination of care with above listed health care provider* *Date*

How did you hear about me (Grand Blanc Therapy)? _____

If it was a person, is it okay if I send a thank-you note for the referral? Yes No

Marital/Relationship Status:
Single (never married) Married Divorced Remarried Widow(er) Long-term Relationship Separated Other

Occupation: _____
Highest Level of Education: _____
If in college/school, please describe where you are at in this process? _____

Are you being treated for any physical health issues/problems? No **Yes - if** yes, please describe:

Are you currently on any medication (oral, injectable)? No **Yes - if** yes, please list name and dosage and reason prescribed for:

Have you ever experienced a concussion, closed-head-injury, or TBI? No **Yes** If yes, please explain:

Lifestyle

Do you…	**No X**	**Yes X**	**Amount of time - per day/week doing this?**	**Follow Up Questions/Clarifying statements**
Drink Alcohol				Amount?
Smoke Cigarettes/Use Tobacco Products				How many?
Smoke Marijuana/use edibles				
Ingest Caffeine				
Currently use prescription pain killers				Which ones:
Ingest – Illicit/Illegal Drugs				Which ones:
Currently have sex with a partner			Amount:	
Enjoy your sex life			If not? Please clarify what you would like to have different?	
Currently, have more than one sexual partner			If yes, have you been tested recently (last 6 months) for STI's? N Y If **yes**, results:	
Feel good about your relationship status			If not, what would you like to see change?	
Feel good about yourself?			If no, describe:	
Practice safer sex			Every Time? Please clarify when:	
Eat a balanced diet				
Exercise regularly				
Do you weigh what you would like to			**If no**, are you under or over weight?	
Practice positive self-talk				
Get enough sleep			Hours:	Have you been tested for sleep apnea? Y N
Work more than 40 hours per week				
Spend time doing fun things			Hours:	What:
Belong to a club and participate regularly				
Have good social support				Family? Friends?
Consider yourself spiritual?				Describe in what way:
Attend Religious service(s)				Religious Preference:
Feel financially secure			If no, please describe why?	
Have a best friend to share with				Who?
See your doctor for annual checkups				
Take all medications as prescribed				
Accept things/situations/people in your life				
See meaning in your life				How?
Have fun on a regular basis				
Have Hobbies				Which ones?

Take annual vacations				
Have Balance in your life: work/family/time for self?			Time:	How would you like this to be different?
If you have children/grandchildren – Do you spend time with them and play with them on a regular basis				Would you like this to be different? Y N

Have you ever been arrested for a crime? N Y Please explain: _____

Have you ever been convicted of a criminal offense? N Y Please explain: _____

Have you ever spent time in jail/prison? N Y Do you have a felony on your record? N Y

Have you ever had your driver's license suspended or revoked? N Y

Have you ever had Child Protective Services (CPS) called on you or your family (past/present)? N Y

Please indicate which best describes your current level of functioning--circle best option.

Work	N/A	Great	Doing Well	Okay	Struggling	Failing
School	N/A	Great	Doing Well	Okay	Struggling	Failing
Social (friends)	N/A	Great	Doing Well	Okay	Struggling	Failing
Goal Setting	N/A	Great	Doing Well	Okay	Struggling	Failing
Meeting Goals	N/A	Great	Doing Well	Okay	Struggling	Failing

How do you get along with Family of Origin (born into): Great Could be better Struggling Cut off

Are your parents living? Y N If alive: are you close with them? Y N

Did your parent's divorced: Y N If yes, how old were you at the time of divorce?

Did either of your parents have "issues" during your formative years? (e.g., drinking, drugs, violent fights, disabilities, rage, etc.)

Do you have siblings?	No	Yes, how many?
If Yes, where are you in the birth order:		
If Yes, what is your current relationship with siblings:		

Please indicate which best describes your current level of functioning--circle best option.

Family of Creation (partnered/have children)	Great	No Issues	Could be better	Struggling	Cut off	
Parenting	N/A	Great	Doing Well	Okay	Struggling	Failing

Please list (step)kids names, gender, age			
Name	Gender	Age	Stepchild?

Please indicate which best describes your current level of functioning--circle best option.

Mood	Happy (most of the time)	Some Happiness	Feel Depressed	No Joy
Anxiety	Extremely Anxious	Some Anxiety (more than I want)	Very little Anxiety	
Concentration	Great	Okay	Struggling	
Memory	Great	Okay	Struggling	
Drive	Highly Motivated	Neutral	Struggling with Motivation	

Acceptance of things and/or people in my life: Doing Okay Struggling with acceptance (describe)

Please describe anything else (you think I should know) in your life that may inform your therapy/treatment? _____

_____

Have you ever sought professional therapy before now? No Yes

If yes, please circle which kind: Individual Couples/Marital Group Substance Abuse

Support Group (e.g., 12 step) Inpatient Treatment Psychiatrist Clergy other

In coming to me for therapy what problem(s) do you wish to resolve? _____

How have you tried to resolve this? _____

How is your life/functioning impaired at this time? (e.g., occupational, interpersonal, thinking, sleeping, legally, etc.)

Do you feel you are currently experiencing any of the following: **Domestic Violence** **Abuse** **Being Controlled**

If so, please describe how:

(*Examples: sexual, emotional, physical, violence, lack of safety*)

Could you describe in the space below if you are experiencing/or have experienced any losses in your life (e.g., death, divorce, fired, etc).

Please circle any of the following items you are currently struggling with:

Temper	Loneliness	My past	Obsessions	Sadness	Concentration	Memory	Finances
Anger	Energy	Shame	Anxiety	Confusion	Sexual Problems	Stress	Over-spending
Rage	Low self esteem	Guilt	Fighting	Insomnia	Nightmares	Depression	Relaxation
Headaches	Fear	Self-control	In-laws	Decision Making	Assertiveness	Inferiority	Religion
Stomach issues	Shyness	Dating	Tiredness	Hopelessness	Resentment	Bitterness	My thoughts