# Novus Vita Counseling, PLLC

"An Integrated Approach to Mental Health"

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## Clinical Intake Form

Name: ____________________________________________ Date:______________________________

DOB:_________________

Referral Source:______________________________________________________________________________

What goals do you hope to achieve through the counseling services?________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

**PRIMARY RELATIONSHIPS** (Current or past)

| | | | | |
|---|---|---|---|---|
| Currently Married | Y | N | How long?____________ | Living with spouse? Y N |
| In committed relationship? | Y | N | How long?____________ | Living with partner? Y N |
| Have you been divorced? | Y | N | When?____________________________ | |
| Have you been widowed? | Y | N | When?____________________________ | |

Name of Spouse/Partner:__________________________________________________________________

**CHILDREN** (include stepchildren)

| First Name | Age | School Grade/Occupation | Living with you now? |
|---|---|---|---|
| | | | Y N |
| | | | Y N |
| | | | Y N |
| | | | Y N |

**FAMILY HISTORY** (Please circle as appropriate: Y=Yes; N=No; U=Unknown)

Were you raised with both biological parents? Y N If no, by whom?____________________________

Were your parents divorced/separated? Y N If yes, how old were you?____________________

Were you raised with step /half siblings? Y N

| | | | |
|---|---|---|---|
| Did you *observe abuse* of any family member in your family of origin? | Y | N | U |
| Were you abused/neglected in your family of origin? | Y | N | U |
| Outside your family of origin, have you experienced abuse? | Y | N | U |

Circle type of abuse: sexual abuse physical abuse emotional abuse harassment

Have you experienced the loss by death of a:

| | | | | |
|---|---|---|---|---|
| Parent? | Y | N | If yes, whom?______________________ | Date:_______________ |
| Other family member? | Y | N | If yes, whom?______________________ | Date:_______________ |
| Close friend? | Y | N | If yes, whom?______________________ | Date:_______________ |

Have your mother, father, or siblings experienced any of the following problems?

| | | | | |
|---|---|---|---|---|
| Alcohol or drug abuse? | Y | N | U | If so, whom?______________________ |
| Significant depression? | Y | N | U | If so, whom?______________________ |
| Suicide attempts? | Y | N | U | If so, whom?______________________ |
| Significant anxiety? | Y | N | U | If so, whom?______________________ |
| Mental Illness? | Y | N | U | If so, whom?______________________ |
| Hospitalization for Emotional/ Psychological Problems? | Y | N | U | If so, whom?______________________ |
| Chronic physical illness? | Y | N | U | If so, whom?______________________ |
| Incarceration (jail/prison) | Y | N | U | If so, whom?______________________ |
| Anger problems? | Y | N | U | If so, whom?______________________ |

**CURRENT USE OF ALCOHOL OR DRUGS**

About how many drinks do you consume in a week?__________How many in a day?________________

In the past year, have you had any of the following occur:

| | | | |
|---|---|---|---|
| Used any mood enhancing prescription drugs? | Y | N | |
| Picked up or charged with a drug related offense? | Y | N | If so, what?__________ |
| Lost time from school or work because of use? | Y | N | U |
| Experienced a medical problem because of use? | Y | N | U |
| Been fired from a job because of use and its effects? | Y | N | U |
| Felt you ought to cut down on your alcohol/drug use? | Y | N | U |
| Have friends/family express concern regarding your alcohol/drug use? | Y | N | U |
| Felt bad or guilty about alcohol/drug use? | Y | N | U |
| Had a drink or used drugs as an "eye opener" first thing in the morning, to steady your nerves, get rid of a hangover, or to get the day started? | Y | N | U |

My average daily nicotine use is?____________________________________________________

My average daily caffeine use is?____________________________________________________

**CURRENT MEDICAL CARE**

Physician:_________________________________________Phone #________________________

Medical Diagnosis:__________________________________________________________________

Medications/Dosage:________________________________________________________________

What type of exercise do you get?_____________________Frequency:_____________________

**PAST MENTAL HEALTH/CHEMICAL DEPENDENCY TREATMENT** (Include outpatient treatment and hospitalizations)

| Dates (MM/YYYY) | Where? | Primary Therapist |
|---|---|---|
| | | |
| | | |
| | | |

**STRESSORS**

Are you experiencing ***significant changes, loss, or difficulties*** in the following areas?

| | | | |
|---|---|---|---|
| Financial | Y | N | U |
| Primary relationship (family/friends) | Y | N | U |
| Housing | Y | N | U |
| Physical Health of self or family member | Y | N | U |
| Access to health care | Y | N | U |
| Occupation/employment | Y | N | U |
| Legal | Y | N | U |
| Education | Y | N | U |

Other___________________________________________

**EDUCATION**

How many years of schooling have you completed?_________________________

Do you hold any degrees or diplomas and if so, which?_________________________

Do you now, or have you ever had a learning disability?_______If so, what?_______________

**EMPLOYMENT**

Are you currently employed? Y N Occupation/Employer_______________________

Are you satisfied with your present job? Y N

Do you think your employer is satisfied with your job performance? Y N

**RELIGION**

Dou you have a religious preference? Y N If yes, what?_______________________

Are your spiritual beliefs an important part of your life? Y N

**LEGAL**

Have you ever been arrested/incarcerated? Y N If so, when?________________

Are you currently on probation/parole? Y N if yes, probation officer:__________

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Over the last two weeks, how often have you been bothered by any of the following problems?*

0=not at all 1=several days 2=more than half the days 3=nearly every day

| | | | | | |
|---|---|---|---|---|---|
| 1. | Little or no interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. | Feeling down, depressed, hopeless | 0 | 1 | 2 | 3 |
| 3. | Trouble falling asleep/staying asleep/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 like you're a failure or you have let others down | 0 | 1 | 2 | 3 |
| 7. | Trouble concentrating such as when reading or watching TV | 0 | 1 | 2 | 3 |
| 8. | Moving or speaking so slowly that others may have noted or being more fidgety or restless than usual | 0 | 1 | 2 | 3 |
| 9. | Thoughts that you'd be better off dead/hurting yourself | 0 | 1 | 2 | 3 |
| • | Trouble with everyday decisions | 0 | 1 | 2 | 3 |
| • | Trouble with important decisions | 0 | 1 | 2 | 3 |
| • | Feeling guilty about things that have happened in the past | 0 | 1 | 2 | 3 |
| • | Difficulty stopping tears/crying | 0 | 1 | 2 | 3 |
| • | Engaging in one or more self-destructive activities | 0 | 1 | 2 | 3 |
| • | Thoughts of killing or harming another | 0 | 1 | 2 | 3 |
| • | Hurting other with your words or actions | 0 | 1 | 2 | 3 |
| • | Experiencing sexual problems | 0 | 1 | 2 | 3 |
| • | Criticizing yourself/getting down on yourself | 0 | 1 | 2 | 3 |
| • | Going for days without needing sleep | 0 | 1 | 2 | 3 |
| • | Experienceing extreme energy changes | 0 | 1 | 2 | 3 |
| • | Making impulsive decisions or increased risk taking | 0 | 1 | 2 | 3 |
| • | Experiencing panic attacks | 0 | 1 | 2 | 3 |
| • | Worrying a lot/unable to relax | 0 | 1 | 2 | 3 |
| • | Difficulty going places by yourself | 0 | 1 | 2 | 3 |
| • | Avoiding (nonfamily) situations | 0 | 1 | 2 | 3 |
| • | Experiencing recurrent distressing dreams | 0 | 1 | 2 | 3 |
| • | Finding it difficult to control your irritability or anger | 0 | 1 | 2 | 3 |
| • | Hearing or seeing things that others do not see or hear | 0 | 1 | 2 | 3 |
| • | Feeling that people are out to get you | 0 | 1 | 2 | 3 |
| • | Experiencing harm or harmful intentions from others | 0 | 1 | 2 | 3 |
| • | Difficulty interacting with others | 0 | 1 | 2 | 3 |
| • | Experiencing intense moods and mood swings | 0 | 1 | 2 | 3 |
| • | Trying to please others to the detriment of your own needs | 0 | 1 | 2 | 3 |
| • | Engaging in excessive checking/hording/cleaning | 0 | 1 | 2 | 3 |

*After completing the list on the previous page, please circle the level of difficulty these problems have created for the following:

<u>Work</u>

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|

<u>Taking care of things at home</u>

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|

<u>Getting along with others</u>

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|

*The PHQ-9 consists of the first 9 items. Copyright held by Pfizer, Inc.

Printed Name of Client | Guardian if Client is under 18 years of age.

Signature of Client | Signature of Guardian

___________________________________

Date:

**CASE HISTORY**