Kenneth R Ellis, Ph.D.
Executive Director

Susan Minsky, Ph.D.
Clinical Director

COLUMBIA COUNSELING CENTER
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OFFICE USE ONLY

Date of Intake:_____

Clinician:_____

**********

Stress Assessment:

150-199 (Mild) _____
200-299 (Mod) _____
Over 300 (Severe) _____

# ADULT INITIAL CLINICAL INTAKE

## IDENTIFICATION:

Name: (First)_____(Last)_____ Date of Birth:_____

Age:_____ Sex:_____ Height:_____ Weight:_____ Ethnic Background:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Do you have children? ☐ Yes ☐ No If yes, give ages and sex: _____

_____

Individuals who live with you:_____

Occupation:_____ Source of Income:_____

How were you referred to Columbia Counseling Center?_____

Have you been here for treatment before? ☐ Yes ☐ No If yes, please list dates and therapist(s):_____

## PRIMARY CONCERNS: (Please check the degree that the following problems are to you.)

| | Mild | Moderate | Severe |
|---|---|---|---|
| Anxiety or Nervousness | ☐ | ☐ | ☐ |
| Depression or Sadness | ☐ | ☐ | ☐ |
| Sleep Difficulties | ☐ | ☐ | ☐ |
| Change in Weight over last 6 months | ☐ | ☐ | ☐ |
| Loss of pleasure in life activities | ☐ | ☐ | ☐ |
| Decreased interest in sex | ☐ | ☐ | ☐ |
| Difficulty concentrating | ☐ | ☐ | ☐ |
| Anger, trouble with temper | ☐ | ☐ | ☐ |
| Thoughts of harming yourself | ☐ | ☐ | ☐ |
| Thoughts of harming others | ☐ | ☐ | ☐ |
| Low self-esteem | ☐ | ☐ | ☐ |
| Hearing or seeing things that are not really there | ☐ | ☐ | ☐ |
| People wanting to harm you | ☐ | ☐ | ☐ |

| | Mild | Moderate | Severe |
|---|---|---|---|
| Panic attacks | ☐ | ☐ | ☐ |
| Fears | ☐ | ☐ | ☐ |
| Racing thoughts | ☐ | ☐ | ☐ |
| Recurring, unwanted thoughts | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ |
| Physical pain | ☐ | ☐ | ☐ |
| Drinking/Substance abuse problem | ☐ | ☐ | ☐ |
| Health problem(s) | ☐ | ☐ | ☐ |
| Job problem | ☐ | ☐ | ☐ |
| School problem | ☐ | ☐ | ☐ |
| Family or marriage problem | ☐ | ☐ | ☐ |
| Physical appearance | ☐ | ☐ | ☐ |
| Loneliness | ☐ | ☐ | ☐ |
| Financial problems | ☐ | ☐ | ☐ |

## HISTORY OF PROBLEM:

In general, how long have you had the above problem(s)?
☐ 1 week ☐ 1 month ☐ 6 months ☐ 1 year ☐ More than 1 year

Circle the changes which have occurred in your life this past year:

| | | | |
|---|---|---|---|
| Death of a spouse | 100 | Foreclosure of mortgage or loan | 30 |
| Marital Separation | 65 | Change in work responsibilities | 30 |
| Death of close family member | 63 | Son or daughter leaving home | 29 |
| Personal injury or illness | 53 | Trouble with in-laws | 29 |
| Marriage | 30 | Outstanding personal achievement | 28 |
| Loss of job | 47 | Wife beginning or stopping work | 29 |
| Marital reconciliation | 45 | Revision of personal habits | 24 |
| Retirement | 45 | Trouble with business superior | 23 |
| Change in health of a family member | 44 | Change in residence | 20 |
| Wife's pregnancy | 40 | Change in schools | 20 |
| Sex difficulties | 39 | Change in recreation | 19 |
| Gain of a new family member | 39 | Change in social activities | 18 |
| Change in financial status | 38 | Taking out small mortgage | 17 |
| Death of a close friend | 37 | Change in sleeping habits | 16 |
| Change to different kind of work | 36 | Change in amount of time with family | 15 |
| Increase or decrease in arguments with spouse | 35 | Change in eating habits | 15 |
| Taking out large mortgage | 31 | Vacation | 13 |
| | | Minor violations of law | 11 |

(Holmes and Rahe Stress Assessment)

## PSYCHOSOCIAL HISTORY:

Mother alive? ☐ Yes ☐ No If yes, mother's age? _____
Mother's education_____ Mother's occupation_____
Relationship to mother during childhood: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Present relationship to mother: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Father alive? ☐ Yes ☐ No If yes, father's age? _____
Father's education_____ Father's occupation_____
Relationship to father during childhood: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Present relationship to father: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Age of brothers:_____ Age of sisters:_____
Was your childhood: ☐ Very happy ☐ Happy ☐ Fairly Happy ☐ Unhappy ☐ Very unhappy
When you were a child, what did you like to do for fun?_____
_____
Religion:_____

## EDUCATION:

What was the last grade you completed?_____
Did you ever repeat any years in elementary or high school? ☐ Yes ☐ No
Did you frequently misbehave in school? ☐ Yes ☐ No
What sort of grades did you receive?
Elementary? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
High school? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
College?(if attended) ☐ Excellent ☐ Good ☐ Fair ☐ Poor
If you attended college, what did you major in?_____
Military service: ☐ Yes ☐ No Branch/ Rank:_____ Years:_____
Marriage/Family:
Currently married? ☐ Yes ☐ No How long?_____
Previous marriage(s)? (List year and length):_____

## OCCUPATION:

Are you currently employed? ☐ Full time ☐ Part time ☐ Unemployed ☐ Other
What sort of work to you do? _____
Do you like your work? ☐ Yes ☐ No
What sort of work have you done in the past? _____

## MEDICAL AND PSYCHIATRIC HISTORY:

List any allergies, serious accidents or illnesses, hospitalizations and the approximate year:

_____

| Please check either Yes or No to the following questions: | | Yes | No |
|---|---|---|---|
| 1. | Have you ever gone to a psychiatrist, psychologist, or any mental health counselor? | ☐ | ☐ |
| 2. | Have you ever been a patient in a mental or psychiatric hospital? | ☐ | ☐ |
| 3. | Have you ever been seriously mentally ill? | ☐ | ☐ |
| 4. | Have you ever attempted to take your own life? | ☐ | ☐ |
| 5. | Have you ever been sexually abused? | ☐ | ☐ |
| 6. | Have you ever been physically abused? | ☐ | ☐ |
| 7. | Have you ever been treated for a drug or alcohol problem? | ☐ | ☐ |
| 8. | Have you ever had a head injury? | ☐ | ☐ |
| 9. | Have you ever had a seizure or convulsion? | ☐ | ☐ |
| 10. | Have you ever been examined by a neurologist? | ☐ | ☐ |
| 11. | Does any member of your family have mental illness or a substance abuse problem? | ☐ | ☐ |
| 12. | Have you ever been in trouble with the law? | ☐ | ☐ |
| 13. | Are you currently taking any medication? | ☐ | ☐ |
| | **List all medication(s) and dosage(s):** _____ | | |

## DRINKING HABITS:

| Do you drink? | Yes | No | Regularly | Seldom | How much? |
|---|---|---|---|---|---|
| Coffee | ☐ | ☐ | ☐ | ☐ | _____ |
| Tea | ☐ | ☐ | ☐ | ☐ | _____ |
| Coke/Pepsi | ☐ | ☐ | ☐ | ☐ | _____ |
| Beer | ☐ | ☐ | ☐ | ☐ | _____ |
| Wine | ☐ | ☐ | ☐ | ☐ | _____ |
| Liquor | ☐ | ☐ | ☐ | ☐ | _____ |

## OTHER SUBSTANCE USE:

| Do you, or have you ever? | Yes | No | If yes, identify specific substance, quantity and frequency |
|---|---|---|---|
| Smoked cigarettes | ☐ | ☐ | _____ |
| Smoked marijuana | ☐ | ☐ | _____ |
| Taken hallucinogens (PCP or LSD) | ☐ | ☐ | _____ |
| Taken sedatives (downers/valium) | ☐ | ☐ | _____ |
| Taken stimulantes (amphetamines/cocaine) | ☐ | ☐ | _____ |
| Taken narcotics (heroin) | ☐ | ☐ | _____ |
| Taken herbs | ☐ | ☐ | _____ |
| Sniffed glue/paint | ☐ | ☐ | _____ |
| Other _____ | ☐ | ☐ | _____ |

What do you do for fun, recreation, or hobbies? _____

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## NEW PATIENT INFORMATION SHEET FOR PROVIDERS

**Patient Name: Last:**_____ **First:**_____

**Spouse Name: Last:**_____ **First:**_____

**Patient Date of Birth:**_____ **Sex: ☐Male ☐Female**

**Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Partner**

**Name of Parent/ Guardian (if applicable):**_____

**Home Phone:**_____ **Cell Phone:**_____ **Work Phone:**_____

**E-Mail:**_____

**Occupation:**_____ **School (if applicable):**_____

**Primary Care Physician:**_____ **Phone:**_____

**Previous Mental Health Treatment (past two years):**

_____

_____

**Referred By:**_____

We take every precaution in protecting the confidentiality of your visits with us, as well as all clinical records. To ensure quality care, staff consultation may be obtained. We do not reveal confidential information without your written consent, except where required by law, such as: If we learn about child abuse or abuse of disabled or elderly adults; If a patient is a danger to himself or others (suicidal or homicidal), or if required by a court order to present records.

Thank you for your cooperation.

***I consent to psychological and/or psychiatric services and treatment for myself or my dependent.***

_____ _____

*Signature of Patient/Guardian* *Date*