LIVING WELL CHRISTIAN FAMILY CLINIC, LLC
INTAKE FORM

REFERRAL SOURCE Insurance ☐ Friend ☐ Pastor ☐ Teacher ☐ Phone book ☐ Web ☐ Other ☐

CLIENT

Name: _____ D.O.B _____ Race: _____
First MI Last
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____ How long: _____
Church: _____ Past Military Experience: _____

SPOUSE / PARENT (if client is a minor child)

Name: _____ D.O.B _____ Race: _____
First MI Last
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____ How long: _____
Church: _____ Past Military Experience: _____

PARENT (if client is a minor child)

Name: _____ D.O.B _____ Race: _____
First MI Last
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____ How long: _____
Church: _____ Past Military Experience: _____

MARITAL INFORMATION

Date married: _____ Present Status: _____
Prior marriages

Husband From _____ to _____ Death ☐ Divorce ☐
Husband From _____ to _____ Death ☐ Divorce ☐
Husband From _____ to _____ Death ☐ Divorce ☐

Wife From _____ to _____ Death ☐ Divorce ☐ Previous name: _____
Wife From _____ to _____ Death ☐ Divorce ☐ Previous name: _____
Wife From _____ to _____ Death ☐ Divorce ☐ Previous name: _____

Children/(Siblings, Step-Siblings)

Name	Age	Grade	Describe relationship with this child
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

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HEALTH REPORT

Name: _____ Age: _____

What childhood diseases did you have? _____

_____

What serious illnesses have you had? _____

_____

What operations have you had? _____

_____

List present ailments: _____

_____

What allergies do you have? _____

Please list any prescription or over-the-counter medications you are currently taking and why:

Medication	Dosage (ie: 15ml)	Frequency (ie: 2 times a day)	Purpose

When was your last physical check-up?_____ Results: _____

_____

How is your appetite? _____Have you lost weight in the last three months? _____Gained? _____

If you have gained or lost weight, how much? _____

Do you exercise? _____ If so, what do you do? _____ How often?_____

How many packs of cigarettes do you smoke each day? _____

How many cups of coffee or tea do you drink each day? _____ Sodas? _____ Alcoholic drinks? _____

Is there a history in your family of any of the following? (Check)

☐ High Blood Pressure ☐ Obesity ☐ Gallbladder Disease ☐ High Cholesterol ☐ Diabetes

☐ Neurological Disease ☐ Cancer ☐ Hypoglycemia ☐ Arthritis ☐ Schizophrenia

☐ Upper respiratory problems ☐ Stroke ☐ Heart Disease ☐ Mental Retardation ☐ Dementia

Other health issues: _____

Name of your Personal Physician: _____ Phone: _____

Clinic Name: _____Clinic Address: _____

City: _____ State: _____Zip: _____ May we contact your Physician? ◯ Yes ◯ No

PRESENTING PROBLEM:

Why are you seeking therapy/counseling? _____

_____

_____

_____

_____

MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT HISTORY:

Please list any prior mental health treatment or counseling (include any hospitalizations or substance abuse treatment):

Dates	Location	Provider	Reason/Outcome

What did you like/dislike about your former experiences with counseling? _____

_____

_____

_____

EDUCATIONAL/VOCATIONAL ISSUES:

Highest Grade Completed: _____ Did you have any learning or behavioral problems while in school?

_____

_____

Are you experiencing any issues related to your job/schooling due to the concern you are being seen for today?

_____

_____

_____

FAITH / SPIRITUALITY:

Do you have any concerns related to your spirituality or faith and the reason you are being seen today that you believe may impact your care? _____

_____

_____

_____

STRESSORS:

Please list any changes in your life that you would consider to be significant in the past several years: _____

_____

_____

_____

Have any of these had a negative or positive effect on your daily life? _____

_____

_____

Completed by: _____Date:_____

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?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	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)]?	0	1	2	3	4	