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 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

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…	**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.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			