Client Name: _____

CLINICAL INFORMATION (circle all that apply and explain "yes" responses below)

Do you have any medical conditions (e.g., diabetes, high blood pressure, heart disease, asthma, etc?) **If yes, please list:**	Yes No
Are you currently prescribed any medications? **If yes, please list:** **Please list any medication allergies:**	Yes No
In the past month has there been a period of time when you were feeling depressed or down most of the day?	Never Sometimes Always
Have you lost interest or pleasure in things you usually enjoy?	Yes No
Any loss of energy?	Yes No
Do you have difficulty with sleep? Falling asleep During sleep Early waking	Yes No Yes No Yes No Yes No
Over the past few years, have you been bothered by depressed mood, felt down or hopeless or had trouble making decisions?	Yes No
Have you ever had a period when you were feeling so good, high, excited, or hyper that others thought you were not your normal self or you got into trouble?	Yes No
(If no:) Has there ever been a time when you were feeling so irritable that you found yourself shouting at people or starting fights or arguments?	Yes No
Have you ever physically hurt yourself or someone else or ever felt like it?	Yes No
Do you often feel angry and act on that anger?	Yes No
Has it ever seemed like people were talking about you or taking special notice of you?	Yes No
Do you ever hear or see things that others cannot hear or see?	Yes No
Have you ever suddenly felt frightened or anxious or suddenly developed a lot of physical symptoms, i.e, sweating, heart pounding, chills, nausea, etc.?	Yes No
Were you ever afraid of going out of the house alone, being alone, being in a crowd, standing in a line or traveling on buses, trains, or anything else?	Yes No
In the past 6 months have you been unrealistically or excessively nervous, anxious, or worried?	Yes No
Is there anything that you have been afraid to do or felt uncomfortable doing in front of other people, such as speaking, eating, writing?	Yes No
Was there ever anything that you felt like you had to do over and over again and couldn't resist doing, such as washing your hands, counting, or checking something several times to make sure you had done it right?	Yes No

Have you ever been bothered by thoughts that didn't make sense and kept coming back to you even when you tried not to have them (e.g. hurt someone you don't want to hurt)?	Yes No
Have you ever been in a life-threatening situation such as a major disaster, serious accident or fire; been physically assaulted or raped; seen another person killed, dead, or badly hurt; or heard about something horrible that happened to someone close to you?	Yes No
(If yes:) Have any of these experiences ever come back to you in the form of nightmares, flashbacks, or th that you can't get rid of?	Yes No
Have you ever become very upset when you were in a situation that reminded you of one of these horrible times?	Yes No
Have you ever been physically, emotionally, or sexually abused (if so, I won't ask you any more Questions now, but will let your clinician know)?	Yes No
Over the past several years, what has your health been like?	Good Fair Not Well
Do you tend to have symptoms that your doctor(s) can't explain or diagnose?	Yes No
Do you worry much about your physical health?	Yes No
Are you bothered by the way you look?	Yes No
Have you ever weighed much less than other people thought you ought to weigh?	Yes No
Do you feel out of control about your eating?	Yes No
Do you vomit or exercise after eating to get rid of the food you just ate?	Yes No
Have you ever tried to cut down or stop drinking?	Yes No
Tobacco Use?	Yes No
Drug use?	Yes No
Gambling?	Yes No
Pornography?	Yes No
(If no:) Did you ever want to or did other people think you should? (alcohol:)	Yes No
Tobacco Use?	Yes No
Drug use?	Yes No
Gambling?	Yes No
Pornography?	Yes No
Do you become angry when others say you should stop alcohol use or comment on it?	Yes No
Tobacco Use?	Yes No
Drug use?	Yes No
Gambling?	Yes No
Pornography?	Yes No
Do you ever feel guilty after you have been drinking?	Yes No
Tobacco Use?	Yes No
Drug use?	Yes No
Gambling?	Yes No
Pornography?	Yes No
Have you ever had to start the day with a drink?	Yes No
Tobacco Use?	Yes No
Drug use?	Yes No
Gambling?	Yes No
Pornography?	Yes No
Do you have any other mental health problems you would like help for that we haven't discussed?	Yes No

Have you received behavioral health treatment in the past?	Yes No
If Yes, please list the dates of service, provider and reason for seeking treatment:	
For Clinician Use: Outcome measure: Est. treatment plan/2nd outcome date:	

Is there any other information that I haven't already asked about that you think would be helpful for us to know, e.g., problems with work, relationships, financial, legal, or socially? _____

Intaker Signature: _____ Date: _____