THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

INTAKE INTERVIEW FORM

Name:_____ **Social Security Number**: _____

Home Address: _____ **Date of Birth**: _____ **Age**: _____

Home Phone: _____ **City/State/Zip code**: _____

Cellular/Alternate Phone: _____

Marital Status: single ◯ married ◯ separated ◯ divorced ◯
remarried ◯ engaged ◯ widowed ◯ cohabiting ◯

I. Family of Origin

A. Where were you born/raised? _____

B. Do you have any siblings? Y☐ N☐
Sibling(s)' names and ages:

What is your birth order? (oldest, middle, etc.) _____

What was it like to be in that position in the family?

C. Are your parents still alive? Y☐ N☐
Have they ever been married? Y☐ N☐
Are your parents still married? Y☐ N☐
Divorces/separations/step-parents? Y☐ N☐
What are your living arrangements? _____

Parents' nationality: Mother _____
Is English her primary language? Y☐ N☐
Father _____
Is English his primary language? Y☐ N☐

Parents' occupation: Mother _____
Father _____

INTAKE INTERVIEW FORM

(page 2)

D. Family Mental Health History:

Anyone have history of drug abuse? Y☐ N☐

Who?

Alcohol addiction? Y☐ N☐

Who?

Mental illness, emotional disorders (depression, anxiety, bipolar, schizophrenia)? Circle all that apply

Who?

Learning disabilities (mental retardation, literacy deficits, hyperactivity) ? Circle all that apply

Who?

E. Have you ever been involved with the legal system?_____If so, please explain. _____

_____

F. Concerns re: family of origin _____

_____

II. Occupation/Education:

Highest level of education achieved? _____

How well do you read and write? _____

Where do you go to school/work? _____

Any special education/disability programs? Y☐ N☐

Explain:

What type of student/employee are you?_____

What are your likes/dislikes about school/work? _____

_____

_____

Current job? _____

Past employment positions (most recent to past):

Any job-related disabilities? Y☐ N☐

Explain:

Concerns re: school/education/work

INTAKE INTERVIEW FORM

III. Medical/Health History

Are you under a doctor's care? Y☐ N☐

Dr.'s name/phone number _____

_____

Do you have any allergies? N☐ Y☐, list _____

Are you currently taking any prescribed medication? Y☐ N☐

Type of medication (s) _____

_____

Other than antibiotics, have you been on prescription medication in the past? Y☐ N☐

List: _____

Do you have any major health related concerns? Y☐ N☐

List: _____

Does your family have a history of health related concerns? Y☐ N☐

Do you smoke cigarettes? Y☐ N☐ How many? _____

Do you ingest caffeine? Y☐ N☐ How much? _____

Do you drink alcohol? Y☐ N☐ How much? _____

Do you ingest non-prescription drugs? Y☐ N☐

What types? _____

Concerns re: medical/health status: _____

_____

_____

_____

_____

_____

Any past trauma/abuse? _____

_____

_____

THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

If applicable, please complete the following:
Partner's Name: _____ **Partner's Age:** _____

Partner's Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

_____
_____
_____
_____
_____

How long has this been going on? _____

What made you come in at this time? _____
_____
_____

What do you hope to gain from this evaluation and/or counseling?

_____
_____
_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____
_____
_____

THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed Mood
- ☐ Feeling Numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Voluntary vomiting
- ☐ Eating less
- ☐ Excessive exercise to avoid weight gain
- ☐ Use of laxatives
- ☐ Are you trying to lose weight?
- ☐ Binge eating
- ☐ Weight gain: _____ lbs
- ☐ Weight loss: _____ lbs.

- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

Sexual Orientation: Heterosexual ◯ Homosexual ◯ Bisexual ◯ Other

Please describe any other symptoms or experiences you have had problems with:

THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Please mark present symptoms with an "X":

	Always	Sometimes	Never
I have complaints of aches and pains			
I prefer to spend more time alone			
I tire easily, have little energy and/or sleep a lot			
I am having trouble with teacher/boss			
I am less interested in school/work			
I act as if I'm riding a motorcycle (hyperactive)			
I am impulsive, act without thinking			
I am distracted easily			
I am afraid of new situations			
I feel sad, unhappy			
I am irritable, angry			
I feel hopeless			
I have trouble concentrating			
I am less interested in friends			
I fight with others			
I hurt others intentionally			
I am abusive to animals			
Others feel that I cannot be trusted alone			
I lie frequently			
I engage in inappropriate sexual behavior			
I hurt myself on purpose			
I steal			
I am shy			
I choose to be absent from school/work			
My school/work performance is dropping			
I am down on myself			
I have trouble sleeping			
I eat poorly and/or have a history of eating disorders			
I worry a lot			
I feel lonely			
I feel like I am a bad person			

INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

	Always	Sometimes	Never
I take unnecessary risks			
I get hurt frequently			
I seem to be having less fun			
Others say that I act younger than other my age			
I don't not listen to rules			
I don't show feelings/emotions			
I don't understand others feelings			
I tease or am verbally abusive to others			
I blame others for troubles			
I hear voices from nowhere			
Recent weight loss or gain and amount_____			
Recent illness, virus or injury			
Irrational fears			
I have slowed or racing thoughts			
I am disoriented			
I worry about my life's outlook			
Labile (frequent mood swings)			
I have difficulty making decisions			
I feel guilty			
I have crying spells			
I have unusual thoughts			
I have irrational fears for my future			
I am tense			
I have memory problems			
I panic over things			
I am compulsive			
Others: (list)			

Are you suicidal or thinking of hurting yourself?_____Or someone else ? _____

Do you commit to talking to your counselor first should you feel seriously suicidal? _____

Date (s) and place (s) of previous out-patient counseling _____

THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Date (s) and place (s) of previous psychiatric treatment/hospitalization _____

_____

Date (s) and place (s) of chemical dependency treatment _____

_____

Have you ever attended AA or anything similar? _____

Have you ever attempted suicide or tried to harm yourself? (when and how) _____

_____

Have you ever attempted to harm someone else? (when and how) _____

Have you ever taken a psychological test? (when and where) _____

IV. Social/Leisure Activities:

List your preferred leisure activities (hobbies, groups/organizations pastimes).

_____

_____

How many close friendships have you established? _____

How often do you engage in social activities? _____

How often do you engage in family activities? With whom? _____

_____

Concerns re: social/leisure activity _____

_____

V. AAT (Animal-Assisted Therapy) Experiences:

Animal experiences _____

Have you ever had a pet? _____

What happened to it? _____

Any AAT previously? _____

Concerns re: animals, fears, environment, etc? _____

VI. Religious Background:

Do you have a preferred denomination? Y ◯ N ◯

THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

INTAKE QUESTIONNAIRE FOR NEW CLIENTS (Adult) Continued

Which ? _____

What is/was your family's primary denomination? _____

Are you currently active in a church? Y ◯ N ◯

Describe _____

Concerns re: religion/spiritual _____

VII. Goals:

What do you want from your counselor in your therapy experience? _____

_____

What do you want to change in your own behavior or attitude? _____

_____

Or in your situation? _____

_____

Do you believe you need medication? Yes ☐ No ☐

Are you open to medication? Yes ☐ No ☐

Do you believe you need hospitalization? Yes ☐ No ☐ Why? _____

How would you describe your childhood? (good, happy, sad, challenging, bad, complicated,traumatic)

Who did you live with growing up?

What is/was your relationship like with that guardian?

How do you feel that your upbringing has impacted your adult life?

Do you have a general distrust of people?

On a scale of 1-10 (10 being the strongest), what would rate your emotional healthiness?

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Would your parent(s) or family member(s) be willing to come in if necessary? Yes ☐ No ☐

Are they willing to support your changes in other ways? (verbally, reading, etc.) Yes ☐ No ☐

Please list the exact transformation goals you have for therapy: _____

_____

_____

_____

_____

_____ _____

Client's signature Date

THE SANDHURST CENTER
OUTCOME FOCUSED TREATMENT

The Holmes-Rahe Scale

Read each of the events listed below and check the box next to any event which has occurred in your life in the last two (2) years. There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units	
Death of Spouse	100	☐
Divorce	73	☐
Marital Separation	65	☐
Gone to jail	63	☐
Death of close family member	63	☐
Personal injury or illness	53	☐
Marriage	50	☐
Fired at work	47	☐
Marital reconciliation	45	☐
Retirement	45	☐
Change in health of family member	44	☐
Pregnancy	40	☐
Sexual Difficulties	39	☐
Gain of new family member	39	☐
Business readjustment	39	☐
Change in financial state	38	☐
Death of a close friend	37	☐
Change to different line of work	36	☐
Increase in arguments with spouse	35	☐
Mortgage over $100,000	31	☐
Foreclosure of mortgage or loan	30	☐
Change in responsibilities at work	29	☐

Life Events	Life Crisis Units	
Son or daughter leaving home	29	☐
Trouble with in-laws	29	☐
Outstanding personal achievement	28	☐
Spouse begins or stops work	26	☐
Begin or end school	26	☐
Change in living conditions	25	☐
Revision in personal habits	24	☐
Trouble with boss	23	☐
Change in work hours or conditions	20	☐
Change in residence	20	☐
Change in schools	20	☐
Change in recreation	19	☐
Change in church activities	19	☐
Change in social activities	18	☐
Mortgage or loan less than $30,000	17	☐
Change in sleeping habits	16	☐
Change in number of family get-togethers	15	☐
Change in eating habits	15	☐
Vacation	13	☐
Christmas alone	12	☐
Minor violations of the law	11	☐

Your Total Score: ____