

## Plains Area Mental Health Center Personal Intake History

*The goal of Plains Area Mental Health Center is to provide the most appropriate services that we can for your current concern(s).*

*With that in mind, we are asking that you complete this information form. Some of the information obtained is required by our accreditation under Iowa Chapter 24 Rules. We are aware that we ask some very personal questions and you may have concerns about answering them at this time. Please understand that we will need this information to determine how best to serve you, our customer. Please complete all sections and mark all areas that apply in each section. This information is confidential and will be maintained as such in accordance with our Privacy Notice provided to you. The staff person you work with at your first appointment will review this form with you and answer any questions you may have. Staff will complete the sections titled "Reviewer's Comments" while meeting with you.*

Consumer Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Please list other names consumer may be known by: \_\_\_\_\_

Primary language of consumer: \_\_\_\_\_ Are interpreter services needed? [ ] No [ ] Yes

Person(s) completing form if other than consumer: \_\_\_\_\_

How did you hear about the Center or who referred you to us? \_\_\_\_\_

Presenting Concern/Reason for seeking treatment: \_\_\_\_\_

### Current Symptoms, Concerns or Reasons for seeking services:

<input type="checkbox"/> Sleeping—not enough <input type="checkbox"/> Sleeping—too much <input type="checkbox"/> Appetite or eating problems <input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Sadness, tearfulness <input type="checkbox"/> Anxiety, nervousness <input type="checkbox"/> Panicky or panic attacks <input type="checkbox"/> Fearfulness or paranoia <input type="checkbox"/> Guilt or shame <input type="checkbox"/> Grief or loss <input type="checkbox"/> Nightmares <input type="checkbox"/> Not assertive enough <input type="checkbox"/> Loss of pleasure <input type="checkbox"/> Loss of interest <input type="checkbox"/> Poor self esteem/image <input type="checkbox"/> Stress or tension	<input type="checkbox"/> Concentration problems <input type="checkbox"/> Fidgety/hyperactive <input type="checkbox"/> Disobedient / discipline issues <input type="checkbox"/> Memory problems <input type="checkbox"/> Confusion <input type="checkbox"/> Anger, hurting others <input type="checkbox"/> Loneliness <input type="checkbox"/> Medical / physical issues <input type="checkbox"/> Sexual problems <input type="checkbox"/> Legal concerns <input type="checkbox"/> Financial concerns <input type="checkbox"/> Court or DHS requires <input type="checkbox"/> Work/school conflict or stress <input type="checkbox"/> Family conflicts <input type="checkbox"/> Marital conflict or stress <input type="checkbox"/> Other relationship problems	<input type="checkbox"/> Thoughts of suicide <input type="checkbox"/> Thoughts about harming self <input type="checkbox"/> Thoughts about harming others <input type="checkbox"/> Other odd or troubling thoughts <input type="checkbox"/> Hearing voices/seeing things <input type="checkbox"/> Alcohol or drug problems <input type="checkbox"/> Sexual abuse victim <input type="checkbox"/> Sexual abuse perpetrator <input type="checkbox"/> Physical abuse victim <input type="checkbox"/> Physical abuse perpetrator <input type="checkbox"/> Emotional abuse victim <input type="checkbox"/> Emotional abuse perpetrator <input type="checkbox"/> Physical health problems <input type="checkbox"/> Housing problems
<b>Other:</b>		

How long have you been experiencing the problem(s)? \_\_\_\_\_

What have you done to address the problem(s)? \_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_

**Now, please rank the above goals in order of importance to you (1 – most important, 2 – next most important, 3+ etc.)**

**SOCIO-ECONOMIC HISTORY**

**Consumer/Family financial situation:**

- no financial problems
- moderate financial problems
- large indebtedness
- poverty/below poverty income
- impulsive spending
- relationship conflicts over finances
- current/previous bankruptcy

**Employment history and current status:**

<u>Current</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Employer:</b> _____ Dates: _____
		Position: _____ # of Hours/Week: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Employer:</b> _____ Dates: _____
		Position: _____ # of Hours/Week: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Employer:</b> _____ Dates: _____
		Position: _____ # of Hours/Week: _____

**Living situation:**

- housing adequate
- homeless
- housing overcrowded
- living in a facility - Name: \_\_\_\_\_
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

**Not currently in the workforce due to:**

- Unemployment     Retirement     Homemaker     Workers Comp
  - Laid Off     Disability     Student     Living in a facility
- Length of Time: \_\_\_\_\_

**Social support system:**

- supportive network \_\_\_ family \_\_\_ friends \_\_\_ church \_\_\_ work
- few friends     no friends     distant from family of origin
- substance-use-based friends

**Describe any past or current significant issues in Financial or Living situation, past or current Employment, or Social Support system:**

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**Reviewer's Comments:**

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**CULTURAL, SPIRITUAL AND RECREATIONAL INFORMATION**

**Cultural / Ethnic (mark all that apply)**

- African American     Other Hispanic \_\_\_\_\_
- Alaskan Native     Puerto Rican
- Asian     Pacific Islander
- Cuban     White
- Mexican     Other: \_\_\_\_\_
- Native American

**Spiritual/Religion (Optional)**

- No religious / spiritual connections/beliefs
- Protestant
- Catholic
- Jewish
- Other: \_\_\_\_\_

**Have you experienced any problems related to your cultural/ethnic/spiritual/religious identity?**  No  Yes Explain: \_\_\_\_\_

**Community / Recreation / Hobbies**

Currently active in community/recreational activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Please explain answers: _____ _____ _____ _____
Formerly active in community/recreational activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Currently engaged in hobbies?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Currently participate in spiritual activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**Reviewer's Comments:**

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**EDUCATIONAL HISTORY AND INFORMATION**

- High School Graduate – School Name/Year: \_\_\_\_\_
- GED – Year \_\_\_\_\_ Focus/Major \_\_\_\_\_
- Tech or Trade School – Name/Dates: \_\_\_\_\_
- Two year degree – School Name/Dates: \_\_\_\_\_
- Four year degree – School Name/Dates: \_\_\_\_\_
- Graduate courses/degree- School Name/Dates: \_\_\_\_\_
- If none of above, highest grade level achieved: \_\_\_\_\_

**School Performance (What kind of student were you?):**

- Excellent  Above Average  Average  Below Average
- Explain: \_\_\_\_\_

**Barriers to Learning:**

- None  Inattention/Focus  Behavioral issues
- Difficulty w/ reading/writing  Emotional issues
- Difficulty w/ mathematics  Other \_\_\_\_\_

**Type of classes attended:**

- Regular  Mix of Regular and Special Education
- Special Education
- Other: \_\_\_\_\_

**Current student**-School Name: \_\_\_\_\_  
 Current Grade: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_  
 Average grades: \_\_\_\_\_ How long at current school? \_\_\_\_\_  
 Extracurricular activities: \_\_\_\_\_  
 Relationship w/ teacher(s): \_\_\_\_\_  
 Relationships w/ peers: \_\_\_\_\_

**Reviewer's Comments:** \_\_\_\_\_

**MILITARY BACKGROUND**

- Never served in military
- Served in: Branch: \_\_\_\_\_ Dates: \_\_\_\_\_ Involved in combat:  No  Yes Where: \_\_\_\_\_
- Service related concern(s):  No  Yes Explain: \_\_\_\_\_

**Discharge Status:**

- Honorable  Other – Explain: \_\_\_\_\_
- Rank at discharge: \_\_\_\_\_

**Reviewer's Comments:** \_\_\_\_\_

**LEGAL HISTORY AND INFORMATION**

- Legal Guardian:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Power of Attorney** for medical matters: Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Conservator/Payee** for financial matters: Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Advance Directives** for inpatient mental health treatment:  No  Yes If yes, explain: \_\_\_\_\_

- Outpatient Mental Health Commitment**  **Court ordered to treatment**
- Alcohol/drug related legal problems**  **Other:** \_\_\_\_\_

Involvement in **Civil Proceedings:**  No  Yes Explain: \_\_\_\_\_

**Department of Human Services** involvement with child/family:  No  Yes Reason: \_\_\_\_\_

List Name and County of DHS Caseworker assigned: \_\_\_\_\_

**Foster care involvement:**  No  Yes Names/dates of foster parent(s): \_\_\_\_\_

Was (or is) consumer **adopted** or involved in **adoption proceedings?**  No  Yes Explain: \_\_\_\_\_

If **minor** and parents were never married or are divorced, how is **custody** structured (e.g., sole, joint, etc.)? \_\_\_\_\_

**Child Support Enforcement Orders** Yes If yes, explain: \_\_\_\_\_



**Family of Origin:**

**Present during childhood:**

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

**Parents' current marital status:**

- married to each other \_\_\_ years
- separated for \_\_\_ years
- divorced for \_\_\_ years
- mother remarried \_\_\_ times
- father remarried \_\_\_ times
- mother involved with someone
- father involved with someone
- mother deceased for \_\_\_ years  
age of consumer at mother's death \_\_\_
- father deceased for \_\_\_ years  
age of consumer at father's death \_\_\_

**Describe parents of consumer:**

	<b>Father</b>	<b>Mother</b>
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____
age of parent	_____	_____

**Describe childhood family experience:**

- outstanding home environment
- normal home environment
- chaotic home environment
- witnessed physical/verbal/sexual abuse toward others
- experienced physical/verbal/sexual abuse from others

**Adults** Please list names/ages of **step-parents:** \_\_\_\_\_

**Adults** – Please list first names/ages of **siblings:** \_\_\_\_\_

**Age consumer left home (if applicable):** \_\_\_\_\_

**Circumstances:** \_\_\_\_\_

**Describe any past or current significant issues in family of origin relationships:** \_\_\_\_\_

**Special circumstances in childhood:** \_\_\_\_\_

**Reviewer's Comments:** \_\_\_\_\_

**MEDICAL HISTORY**

**Describe current physical health:**  Good  Fair  Poor

**List name of consumer's primary care physician:**  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Will you authorize communication with the primary care physician?  
 No  Yes  
 Date and Reason for last visit: \_\_\_\_\_

**List name of consumer's psychiatrist: (if any):**  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Will you authorize communication with the psychiatrist?  
 No  Yes  
 Date and Reason for last visit: \_\_\_\_\_

**Allergies**  None Known; List all known: \_\_\_\_\_

**Is there history of any of the following in Consumer or Family:**

- |  |                          |                                |                          |
|--|--------------------------|--------------------------------|--------------------------|
| <b>C</b>                                 | <b>F</b>                 | <b>C</b>                       | <b>F</b>                 |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| tuberculosis                             |                          | heart disease                  |                          |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| birth defects                            |                          | high / low blood pressure      |                          |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| head / brain injury                      |                          | fibromyalgia / muscle pain     |                          |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| mental retardation                       |                          | stroke                         |                          |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| headaches                                |                          | asthma / lung disease          |                          |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| thyroid problems                         |                          | diabetes                       |                          |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| cancer                                   |                          | Alzheimer's disease / dementia |                          |
| <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/> |
| other chronic or serious health problems |                          |                                |                          |

**Describe any serious hospitalizations, accidents or surgeries. Please include dates, ages, and which of the above it was:** \_\_\_\_\_

**List any abnormal lab test results including date and result:** \_\_\_\_\_

**Current medication usage?**  No  Yes If yes, please complete:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

**Please list any Herbal Remedies currently used:** \_\_\_\_\_  
 (e.g., Black Cohosh, Dong Quai, Ephedra, Garlic, Ginko, Ginseng, Goldenseal, Milk Thistle, Scotch Broom, St. John’s Wort)

**Nutritional / Eating / Sleeping Habits:**  
 How many meals do you eat a day? \_\_\_\_\_ How many snacks in a normal day? \_\_\_\_\_  
 Are you  underweight  overweight by how many pounds \_\_\_\_\_ Special diet?  No  Yes Explain: \_\_\_\_\_  
 Has your weight changed in the last six months?  No  Yes Explain: \_\_\_\_\_  
 Do you have problems with:  chewing  swallowing  choking  nausea  binge eating  purging (purposeful vomiting)  
 Please describe the consumer’s **typical night’s sleep:** \_\_\_\_\_

**Reviewer’s Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DEVELOPMENTAL HISTORY- Required for Children/Adolescents – (ADULTS OPTIONAL)**

<p><b>Mother’s problem(s) during pregnancy:</b>  <input type="checkbox"/> none  <input type="checkbox"/> high blood pressure  <input type="checkbox"/> kidney infection  <input type="checkbox"/> German measles  <input type="checkbox"/> emotional stress  <input type="checkbox"/> bleeding  <input type="checkbox"/> alcohol use  <input type="checkbox"/> drug use  <input type="checkbox"/> cigarette use  <input type="checkbox"/> other _____</p>	<p><b>Birth:</b>  <input type="checkbox"/> normal delivery  <input type="checkbox"/> difficult delivery  <input type="checkbox"/> cesarean delivery  <input type="checkbox"/> complications _____  <input type="checkbox"/> premature birth, by # of weeks _____  <input type="checkbox"/> birth weight ___lbs __oz  <b>Infancy:</b>  <input type="checkbox"/> feeding problems  <input type="checkbox"/> sleep problems  <input type="checkbox"/> toilet training problems</p>	<p><b>Childhood health:</b>  <input type="checkbox"/> chickenpox (age _____)  <input type="checkbox"/> German measles (age _____)  <input type="checkbox"/> red measles (age _____)  <input type="checkbox"/> rheumatic fever (age _____)  <input type="checkbox"/> whooping cough (age _____)  <input type="checkbox"/> scarlet fever (age _____)  <input type="checkbox"/> autism  <input type="checkbox"/> ear infections  <input type="checkbox"/> allergies to _____  <input type="checkbox"/> significant injuries _____  <input type="checkbox"/> chronic, serious health problems _____</p>	<p><input type="checkbox"/> lead poisoning (age _____)  <input type="checkbox"/> mumps (age _____)  <input type="checkbox"/> diphtheria (age _____)  <input type="checkbox"/> poliomyelitis (age _____)  <input type="checkbox"/> pneumonia (age _____)  <input type="checkbox"/> tuberculosis (age _____)  <input type="checkbox"/> mental retardation  <input type="checkbox"/> asthma</p>
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<p><b>Delayed developmental milestones</b> (mark only those milestones that did not occur at expected age):  <input type="checkbox"/> sitting <input type="checkbox"/> controlling bowels  <input type="checkbox"/> rolling over <input type="checkbox"/> sleeping alone  <input type="checkbox"/> standing <input type="checkbox"/> dressing self  <input type="checkbox"/> walking <input type="checkbox"/> engaging peers  <input type="checkbox"/> feeding self <input type="checkbox"/> tolerating separation  <input type="checkbox"/> speaking words <input type="checkbox"/> playing cooperatively  <input type="checkbox"/> speaking sentences <input type="checkbox"/> riding tricycle  <input type="checkbox"/> controlling bladder <input type="checkbox"/> riding bicycle  <input type="checkbox"/> other _____</p>	<p><b>Emotional / behavior problems</b> (mark all that apply):  <input type="checkbox"/> drug use <input type="checkbox"/> echoes words of others <input type="checkbox"/> distrustful  <input type="checkbox"/> alcohol abuse <input type="checkbox"/> not trustworthy <input type="checkbox"/> extreme worrier  <input type="checkbox"/> chronic lying <input type="checkbox"/> hostile/angry mood <input type="checkbox"/> self-harm acts  <input type="checkbox"/> stealing <input type="checkbox"/> indecisive <input type="checkbox"/> impulsive  <input type="checkbox"/> violent temper <input type="checkbox"/> immature <input type="checkbox"/> easily distracted  <input type="checkbox"/> fire-setting <input type="checkbox"/> bizarre behavior <input type="checkbox"/> poor concentration  <input type="checkbox"/> hyperactive <input type="checkbox"/> self-harm threats <input type="checkbox"/> often sad  <input type="checkbox"/> animal cruelty <input type="checkbox"/> frequently tearful <input type="checkbox"/> breaks things  <input type="checkbox"/> assaults others <input type="checkbox"/> frequently daydreams <input type="checkbox"/> disobedient  <input type="checkbox"/> lack of attachment <input type="checkbox"/> other _____</p>
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**Social interaction** (mark all that apply):

- normal social interaction
- isolates self
- very shy
- gang involvement
- alienates self
- inappropriate sex play
- dominates others
- associates with acting-out peers
- problems with authority
- other \_\_\_\_\_

**Intellectual / academic functioning** (mark all that apply):

- normal intelligence
- high intelligence
- learning problems
- authority conflicts
- attention problems
- underachieving
- mild retardation
- moderate retardation
- severe retardation

**Describe any other developmental problems or issues:** \_\_\_\_\_

Please describe how parents / caregivers **discipline and the consumer's response:** \_\_\_\_\_

**Reviewer's Comments:** \_\_\_\_\_

**EMOTIONAL/PSYCHIATRIC HISTORY**

**Prior outpatient psychotherapy?**  No  Yes, please list:

Prior provider name	City	State	Dates	Diagnosis/Reason	Intervention/Modality	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**Has any family member had outpatient psychotherapy?**  No  Yes If yes, who/why (list all): \_\_\_\_\_

**Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**  No  Yes, please list:

Inpatient facility name	City	State	Dates	Diagnosis/Reason	Intervention/Modality	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?**  No  Yes If yes, please list who/why (list all): \_\_\_\_\_

**Prior psychiatric medication usage?**  No  Yes, please list:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial – Y or N?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

**Has any family member used psychiatric medications?**  No  Yes If yes, who/what/why (list all): \_\_\_\_\_

**Reviewer's Comments:** \_\_\_\_\_

**SUBSTANCE USE HISTORY**

<b>Substances used: (check &amp; complete all that apply)</b>	<b>Current Use (Yes/No)</b>	<b>Age of first use</b>	<b>Age of last use</b>	<b>Frequency</b>	<b>Amount</b>	<b>Method of Use</b>
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> tobacco / nicotine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> anabolic steroids	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/downers	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> ecstasy	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> hashish	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> heroin	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> methamphetamine	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> prescription med misuse	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> other _____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> other _____	_____	_____	_____	_____	_____	_____

**Primary substance(s) of choice:** 1<sup>st</sup>: \_\_\_\_\_ 2<sup>nd</sup>: \_\_\_\_\_ 3<sup>rd</sup>: \_\_\_\_\_

**Benefits of substance use:** What benefits and/or reasons do you have for using the above substances? \_\_\_\_\_

**Consequences of substance use** (mark all that apply):

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> hangovers      | <input type="checkbox"/> withdrawal symptoms         | <input type="checkbox"/> sleep disturbance     | <input type="checkbox"/> binges                      |
| <input type="checkbox"/> seizures       | <input type="checkbox"/> medical conditions          | <input type="checkbox"/> assaults              | <input type="checkbox"/> school suspension/expulsion |
| <input type="checkbox"/> blackouts      | <input type="checkbox"/> tolerance changes           | <input type="checkbox"/> suicidal impulse      | <input type="checkbox"/> arrests / legal involvement |
| <input type="checkbox"/> overdose       | <input type="checkbox"/> loss of control amount used | <input type="checkbox"/> job loss / suspension | <input type="checkbox"/> relationship conflicts      |
| <input type="checkbox"/> other(s) _____ |  |  |  |

**Consumer's Substance use status:**

- no history of use or problems
- past use / no longer using
- occasional use / social
- active use – problematic
- early in recovery

**Consumer's Treatment history:**

- outpatient (age[s] \_\_\_\_\_)
- inpatient (age[s] \_\_\_\_\_)
- 12-step program (age[s] \_\_\_\_\_)
- stopped on own (age[s] \_\_\_\_\_)
- other (age[s] \_\_\_\_\_)  
describe: \_\_\_\_\_

**Family history of Alcohol/Drug problems:**

- |  |  |
|--|--|
| <u>A</u> <u>D</u>  | <u>A</u> <u>D</u>  |
| <input type="checkbox"/> <input type="checkbox"/> father         | <input type="checkbox"/> <input type="checkbox"/> stepparent/live-in       |
| <input type="checkbox"/> <input type="checkbox"/> mother         | <input type="checkbox"/> <input type="checkbox"/> uncle(s)/aunt(s)         |
| <input type="checkbox"/> <input type="checkbox"/> grandparent(s) | <input type="checkbox"/> <input type="checkbox"/> spouse/significant other |
| <input type="checkbox"/> <input type="checkbox"/> sibling(s)     | <input type="checkbox"/> <input type="checkbox"/> children                 |
| <input type="checkbox"/> <input type="checkbox"/>                |  |

**Reviewer's Comments:** \_\_\_\_\_

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**VIOLENCE / ABUSE HISTORY**

- |   |   |                                 |                                      |
|---|---|---------------------------------|--------------------------------------|
| <input type="checkbox"/> No history of violence / abuse | <input type="checkbox"/> Emotional Abuse          | <input type="checkbox"/> victim | <input type="checkbox"/> perpetrator |
| <input type="checkbox"/> Physical Abuse                 | <input type="checkbox"/> Domestic Violence        | <input type="checkbox"/> victim | <input type="checkbox"/> perpetrator |
| <input type="checkbox"/> Physical Neglect               | <input type="checkbox"/> Sexual Abuse/Molestation | <input type="checkbox"/> victim | <input type="checkbox"/> perpetrator |
| <input type="checkbox"/> Community Violence             | <input type="checkbox"/> Elder Abuse              | <input type="checkbox"/> victim | <input type="checkbox"/> perpetrator |

Please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Reviewer's Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SEXUAL ORIENTATION, HISTORY AND INFORMATION (optional)**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> child or unknown   | <input type="checkbox"/> heterosexual orientation  | <input type="checkbox"/> homosexual orientation          | <input type="checkbox"/> bisexual orientation              |
| <input type="checkbox"/> currently sexually active  | <input type="checkbox"/> currently sexually satisfied  | <input type="checkbox"/> currently sexually dissatisfied | <input type="checkbox"/> age first sexual experience _____ |
| <input type="checkbox"/> age first pregnancy / fatherhood _____                               | <input type="checkbox"/> history of multiple partners: age _____ to _____; number of partners: _____ |  |  |
| <input type="checkbox"/> history of unprotected / unsafe sex, please list: age _____ to _____ |  |  |  |

**Are sexual issues an area of concern for you at this time?**  No  Yes If yes, please explain additional information you may wish: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Reviewer's Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**To the best of my knowledge, what I have said is true and I have not withheld any information.**

**Signature of person completing form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Information for this Personal Intake History has been provided by (mark all that apply)**

- |   |  |                                      |  |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> Consumer         | <input type="checkbox"/> Parent(s)       | <input type="checkbox"/> Guardian(s) | <input type="checkbox"/> Family/Friend                           |
| <input type="checkbox"/> Physician        | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Records     | <input type="checkbox"/> Other Service Provider Interview: _____ |
| <input type="checkbox"/> School Personnel | <input type="checkbox"/> Other: _____    |                                      |  |

**Signature/Credentials/ID# of person reviewing form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Family Genogram

(Staff – If preferred, please complete genogram of consumer’s family in the space below using these symbols as a guide)

□	○	—	/	//	m.60	s.72	d.74	X	43-75	---	....	≡
Male (double lines around client)	Female	Relationship	Separated	Divorced	Married date	Separated date	Divorced date	Death	Birth – Death date	Living together	Distant relationship	Very close relationship

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