INTAKE QUESTIONNAIRE – ADULT

Location: ◉ Lake Geneva Wellness Clinic, LLC
750 Veterans Parkway, Suite 100
Lake Geneva, WI 53147
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ABOUT YOU

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Birth (Legal) Name:_____ Today's Date:____/____/_____
Preferred Name: _____
If you have had services here before, under what name?_____
Address:_____ _____
City State Zip Code
Home Phone: _____ Work Phone:_____ Email:_____
Living Situation (who lives in your home with you): _____ Your Birth Date:_____ Where were you born?_____ Marital Status: ----------

Employer's Name :_____ Address:_____
City____ State Zip Code |

Gender:_____ Preferred Pronouns:_____

Race/Ethnicity:

- ☐ White/Caucasian
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander

Sexual Orientation: _____

Disability:
Do you have a disability? ◯ Yes ◯ No If yes, please specify: _____
If you have a disability, does the office accommodate your needs? ◯ Yes ◯ No
If no, please explain:

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

_____

Who referred you to the Wellness Clinic?_____

PLEASE LIST ANY SCHOOL AND COLLEGES YOU ATTENDED, ALONG WITH DIPLOMAS, DEGREES AND APPROXIMATE DATE OF AWARD

Name of School	**Diploma or Degree**	**Year(s)**

Military Service: ◯ NO ◯ YES **If Yes, Length of Duty _____** **Honorable Discharge** ◯ NO ◯ YES

Spirituality:
How Important Are Spiritual Matters To You?
◯ Not At All ◯ A Little ◯ Very Important

Are you affiliated with any spiritual or religious group? ◯ NO ◯ YES Describe _____

Would you like to discuss spiritual matters with your counselor in relation to helping with your present issues?
◯ NO ◯ YES ◯ Maybe

ABOUT YOUR SPOUSE OR SIGNIFICANT OTHER:

Check all that apply: ☐ Married ☐ Legally Separated ☐ Divorced ☐ Partner

If married or with a partner, how long have you been together?_____

Name of your significant other:_____ Is your significant other employed? ----------
If so, where?_____

What does she/he do?_____

Do you have any concerns or questions about your significant other or relationship status that we should be aware of, or that you would like to discuss? ◯ Yes ◯ No

If yes, please briefly note them here:

_____

_____

ABOUT YOUR CHILDREN:

Do you have children: ☐ Yes ☐ No – If no, go to next section "Family History"

Names and age of children: (include stepchildren living with you)
NAME---- AGE----- D/O/B NAME----AGE----D/O/B NAME----AGE----D/O/B

_____

_____

_____

_____

FAMILY HISTORY:

Is your father living? --------- If not, approximate date of death:_____
Do you have a healthy relationship with your father? ◯ Yes ◯ No
What was your father's occupation?_____

Is your mother living? ------- If not, approximate date of death:_____
Do you have a healthy relationship with your mother? ◯ Yes ◯ No
What was your mother's occupation?_____

Briefly describe the quality or nature of your relationship with your parents and note any questions or concerns you might wish to raise regarding that relationship:

_____

_____

Do you have siblings, including stepfamily? ◯ Yes ◯ No
Please list your siblings and their ages.

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LEGAL HISTORY:

Have you had any involvement with the legal system: ◯ Yes ◯ No

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

_____
_____
_____
_____
_____

PRESENTING PROBLEM (current situation and history):

1. What is the primary problem for which you are seeking help? (please check)

☐ Marriage or relationship	☐ Problems with children	☐ Grieving
☐ Family problems	☐ Peer problems	☐ Abuse or trauma
☐ Depression	☐ Eating disorder	☐ Sexual functioning
☐ Mood swings	☐ Alcohol/drug use	☐ Anger
☐ Behavior	☐ Physical problems	☐ Anxiety or worry
☐ Self-confidence	☐ Work related	☐ Other (explain):

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? ◯ Yes ◯ No

Previous Mental Health Treatment

	YES/NO	When	Where	Outcome
Counseling?	☐ Yes ☐ No			
Psychiatric Treatment?	☐ Yes ☐ No			
Past/Current Diagnosis?	☐ Yes ☐ No			
Self Injury?	☐ Yes ☐ No			
Suicidal Thoughts?	☐ Yes ☐ No			
Suicide Attempt?	☐ Yes ☐ No			
Danger to Others?	☐ Yes ☐ No			

MEDICAL HISTORY:

Name of Primary Care Family Physician _____

Primary Care Family Physician's Address:_____
Phone #_____ Would you like us to coordinate care with your PCP? ☐ Yes ☐ No
Date of last physical examination_____ (If Yes, MUST fill out ROI)

List any past or present illnesses, infirmities or disabilities of any consequence:

_____

Please list significant hospitalizations, operations, injuries (including broken bones):

_____

All Medications You Are Taking (prescribed or otherwise):

_____

_____

***Please rate the severity of any current or recent (within the past 6 months) symptoms or problems by assigning either a 1,2,3,4 or 5 from the following scale:**

1- Very mild 2-Somewhat mild 3-Moderate 4-Somewhat Severe 5-Severe

_____a. anxiety, tension, nervousness	_____n. muscle tension/ spasticity/ cramps
_____b. coldness or numbness in fingers	_____o. heart palpitations or pounding
_____c. frequent or severe headaches	_____p. frequent worrying/ preoccupation
_____d. skin problems (i.e. rash, acne or dermatitis)	_____q. stiffness, aching or burning sensation in joints
_____e. frequent upset stomach/ indigestion/ nausea	_____r. lack of energy/ frequent fatigue or sluggishness
_____f. depression or crying spells	_____s. lack of appetite
_____g. chronic pain (specify_____)	_____t. excessive appetite
_____h. dizziness or fainting spells	_____u. shortness of breath/ rapid breathing
_____i. diarrhea or constipation/ urinary problems	_____v. problems with falling asleep
_____j. memory problems/ inability to concentrate	_____w. frequent wakening/ early wakening
_____k. excessive alcohol, drug or medication use	_____x. excessive energy/ hyperactivity
_____l. excessive caffeine use (e.g. coffee, tea, chocolate, soda)	_____y. sexual functioning problems
_____m. high blood pressure/ hypertension	_____z. irritability/ temper control problems
	_____ Other:_____

HISTORY OF TRAUMA:

Have you ever been molested or sexually abused? ◯ Yes ◯ No

Have you faced any trauma in your life, physically, verbally or emotionally…? If Yes, Please Explain:

_____

_____

_____

DEVELOPING A TREATMENT PLAN:

1. What are your strengths? _____

_____

2. What are your weaknesses? _____

_____

3. Rate your current overall Wellness (1 = the lowest, 10 = your best) _____

4. What goals would you like to see reached as a result of therapy?

_____

_____

_____

5. What level of improved Wellness would you like to achieve? (scale of 1 – 10) _____

6. How will you know when these goals have been reached?

_____

_____

7. If the problem that caused you to seek help were to be gone tomorrow, how would your life be different?

_____

_____

_____

THERAPIST REVIEW

Signature: 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, check 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	

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: HERE **This is your ACE Score**