A Seed of Hope Family Counseling Center, PLLC
10332 Shaver Road
Portage, MI 49065
(269) 743-7357

Intake Questionnaire

Date: _____

Name:_____ SSN:_____
Home Address: _____ DOB:_____

Home Phone:_____ City, State/Zip:_____

Cell Phone:_____
Are we authorized to leave a text message on your cell phone:_____/Initial____.
Are we authorized to leave a voice message on your cell phone:_____/Initial_____.

Email address: _____
Please review our Informed Consent, Information and Policies regarding use of email correspondence

IF applicable, please complete the following:

Partner's Name:_____ Partners Age:_____

Partner's Occupation:_____

RESPONSIBLE PARTY _ Responsible Party's SSN _____ *(If client is a minor, the responsible party is the parent or guardian bringing the minor for treatment and signing this form)*

If different from client:

Address _____ City, State _____ Zip _
_____

INSURANCE

PRIMARY INSURANCE	**SECONDARY INSURANCE**
POLICY HOLDER'S NAME:	POLICY HOLDER'S NAME:
DOB:	DOB:
SSN:	SSN:
Employer:	Employer:
Group Number:	Group Number:

Member Number:

Home /Cell Phone :

Relationship to Patient:

Member Number

Home/Cell Phone:

Relationship to Patient:

REFERRAL INFORMATION

How did you find out about ASOH (check appropriate box)?

_____Family Member _____Friend(s)/ Neighbors _____Web Search/Internet

_____School System _____Lawyer/Mediator _____Therapist _____Physician/Family Doctor
_____Church/Synagogue _____Other (please specify)

_____

AUTOMATED APPOINTMENT REMINDERS

How would you like to receive appointment reminders (Check ONE option only)?

_____Via text message to my cell phone number (_____) _____
(normal text message rates may apply)

_____Via email message to the following email address:

_____

_____Via automated telephone message to my home or cell phone number (_____)

_____

_____None of the above, I'll remember my appointments on my own

Appointment information is considered "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

_____ _____

Signature Date

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

_____
_____
_____
_____
_____

How long has this been going on?_____

What made you come in this time?

_____
_____

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

_____
_____
_____
_____
_____

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

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before? _____y _____N

Name of therapist:_____ Treatment Date:_____

Organizations Name:_____ Reason for seeking help:_____

Name of therapist:_____ Treatment Date:_____

Organizations Name:_____ Reason for seeking help:_____

Are you **CURRENTLY t**aking **PYSCHIATRIC M**edication? _____y_____N

Name:_____Amount_____How long have you been taking it?_____

Name:_____Amount_____How long have you been taking it?_____

Name:_____Amount_____How long have you been taking it?_____

Name:_____Amount_____How long have you been taking it?_____

Are you **CURRENTLY t**aking **NON-PYCHIATRIC** medication? _____N_____Y

Name:_____Amount_____How long have you been taking it?_____

Name:_____Amount_____How long have you been taking it?_____

Name:_____Amount_____How long have you been taking it?_____

Have you been on **PYCHIATRIC medication** in the **past**? _____Y_____N

Name:_____Amount_____How long have you been taking it?_____

Name:_____Amount_____How long have you been taking it?_____

Have you been hospitalized for psychiatric reasons? _____Y_____N

Have you ever attempted suicide? _____y_____N Dates:_____

List any PRIOR illnesses, operations and accidents:

_____
_____

PLEASE MARK ALL THAT APPLY: (If more than one client, please separately initial)

☐ Excessive crying	☐ Impulsive, acts without thinking	☐ Problems in relationships with partner or children	☐ Feels bullied or picked on
☐ Decreased energy	☐ Can't sit still, antsy	☐ History of traumatic experiences	☐ Has few or no friends
☐ Feelings of being worthless	☐ Always on the go, hyper	☐ Full of energy, little need for sleep	☐ Considered weird by others
☐ Thoughts of suicide	☐ Problems following rules	☐ Feeling overly important	☐ Socially awkward or inappropriate
☐ Feeling overwhelmed, trouble making decisions	☐ Difficulty with authority	☐ Talking fast and excessively	☐ Lacks physical boundaries with peers
☐ Experiencing panic attacks	☐ Unmotivated, Procrastinating	☐ Hoarding food or objects	☐ Skin picking, hair pulling, nail biting
☐ Excessive worrying	☐ Problems with work or school	☐ Poor body image	☐ Inflexible, trouble handling change
☐ Avoiding going places	☐ Apathetic, doesn't seem to care	☐ Problems with eating or food	☐ Self-injury or cutting
☐ Isolating from others	☐ Angry, easily irritated	☐ Stomachaches, digestion	☐ Problems in relationships

		issues	with parents
☐ Checking things repeatedly	☐ Abruptly changing moods	☐ Trouble managing pain or disabling condition	☐ Problems in relationships with friends, siblings, roommates
☐ Afraid of being judged or rejected	☐ Difficulty controlling temper	☐ Lots of aches and pains	☐ Trouble sleeping, nightmares
☐ Sensitive to criticism	☐ Reckless behaviors, taking excessive risks	☐ Legal problems	☐ Suspicious, paranoid
☐ Needs things to be perfect	☐ Abusive toward others	☐ Financial concerns	☐ Threatens or bullies others
☐ Excessive anxiety about separation from caregivers	☐ Lying, stealing	☐ Sexual concerns	☐ Thoughts of hurting others

Have you ever been arrested? _____

If so please describe:_____

Are you currently employed?_____If yes, employer's name_____

What type of work do you do?_____

Do you have a religious affiliation, if so please indicate:_____

Please identify your strengths and weakness:

<u>SUBSTANCE USE:</u>

Alcohol

Do you drink alcohol? _____If yes, age of first use:_____

How much do you drink?_____

How often do you drink?_____ Do you pass out?_____ /How often?

Do you black out?_____/How often?

Do you experience the "shakes"? _____ How often:_____

Have you ever felt you should cut down on your drinking?_____

Have people annoyed you by criticizing your drinking?_____

Have you ever drank in the morning to steady your nerves or relieve a hangover?_____

Do you smoke/vape? _____ If so, how often?

Drug	Ever Used?	Fist Use	Last Use	Approx use in last 30 days

Marijuana				
Cocaine				
Crack				
Methamphetamine				
Ecstasy				
Other:				

EDUCATION:

HIGHEST LEVEL COMPLETED?_____ ADHD/ADD_____Y_____N. TYPE OF GRADES_____
ACTIVITIES_____ DESCRIBE YOUR EXPERIENCE IN HIGH SCHOOL_____

Who do you typically turn to for help with your problems:_____

Have you ever been abused (physically, verbally, emotionally, sexually or neglected) please describe:
_____
_____

FAMILY HISTORY

Father:_____Age:_____Living:_____

If Deceased Date:_____Occupation:_____

Frequency of contact:_____

Father: _____Age:_____Living:_____

If Deceased Date:_____Occupation:_____

Frequency of contact:_____

If you have children please list their names, relationship, ages and if your close to him/her:

#1:_____Y/N

#2:_____Y/N

#3:_____Y/N

#4:_____Y/N

Have you been married previously?_____

Please place a check mark in the appropriate box if these are or have been present in your relatives:

	Children	Brothers	Sisters	Father	Mother	Grandparents	Aunt/Uncle
Depression							
Anxiety							
Hyperactivity							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							

Death by Suicide							
Substance Use Disorder (Alcohol, Opiates, Cocaine, etc.)							