RSI Behavioral Health Services Intake Information

Identifying Information

Name:____Today's Date:_______________________

Phone:____________________ Address:____

DOB:______________ Gender: ___________ Ethnicity or Cultural background:______________________

Marital/ Family Status: Single Partnered Married Divorced Separated Parent of Child/ren

Insurance/Payment information: MA #__________________________Other Payment?________________
(Current payment must be billable to fee-for-service MA, or private pay by client)

How did you find out about Outpatient Therapy Services? ______________________________________

What is your primary reason for seeking Outpatient Therapy Services?____
____
____

Have you received outpatient mental health services in the past 12 months? Y N
If yes, list provider's name and location/agency____

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Areas of concern – please note frequency/intensity if applicable. Feel free to ask your therapist about any area you are unsure how to answer.

Physical:
Sleep Problems_______________________________Fatigue/Loss of energy_____________________________
Appetite change/ Wt. loss or gain___________________________Headaches____________________________
Nausea, diarrhea, other stomach distress____________________Dizziness or faintness____________________
Shortness of breath________________________________Trembling or shaking__________________________
Trouble swallowing or "lump" in throat_____________Heart palpitations/ increased heart rate______________
Nightmares/frightening dreams________________________Premenstrual Syndrome (PMS)________________

Mood:
Depressed mood___________________________________Lonliness____________________________________
Frequent crying_____________________________________Irritability____________________________________
Feelings of hopelessness or helplessness_______________Lack of interest in most activities______________
Low self-esteem____________________________________Thoughts about suicide____________________________
Suicide plans_______________________________________Suicide attempts_________________________________

Anxiety:
Excessive worry________________________________Stress, nervousness________________________________
Panic attacks___________________________________Fears or phobias__________________________________
Social fears, shyness_______________________________Guilty feelings__________________________________

Behavior:
Withdrawal, isolation______________________________Lack of assertiveness____________________________
Perfectionism_________________________________Hyperactivity_____________________________________
Aggressive behavior__________________________Risk taking or dangerous behavior____________________
Self- harm___________________________________Gambling____

Thoughts, perceptions:
Problems with memory____________________________Difficulty concentrating___________________________
Trouble thinking, confusion_________________________Racing thoughts______________________________
Excessive fantasy, daydreaming_________________________Hallucinations_____________________________
Preoccupation, recurring or intrusive thoughts____

Please list current medications:____
____
____

Substances:
Do you use alcohol? Yes No How often?____
Do you use drugs? Yes No How often, which drugs?____
Have you ever wanted to reduce your drinking or drug use? Yes No
Have people annoyed you by criticizing your drinking or drug use? Yes No
Have you ever felt bad or guilty about your drinking or drug use? Yes No
If you are in recovery, how long have you been sober?____
Do you smoke cigarettes? Yes No Amount per day?____
Do you drink caffinated beverages? Yes No Amount per day?____

What do you view as your personal strengths and resources?_____________________________________
____

Social and Family History:
Highest level of schooling competed_________________________________ Degrees earned________________
Are you employed? Yes No Type of employment____
Social network: Please describe number and quality of friendships____________________________________
____
____
Financial Issues____
Legal Issues____

Your parents: married separated divorced never married step-parent(s)? Yes No
Number of brothers______ Number of sisters_____
Have you ever experienced: emotional abuse sexual abuse physical abuse verbal abuse trauma
Has anyone in your family experienced emotional or mental-health problems? Yes No Don't know
Relation: __________________________Problem:____
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Relation: __________________________Problem:____

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Signature of person completing form, and relationship to client (if not client) Date