

FREMONT COUNSELING SERVICE

Demographics Form

Client's Last Name _____ Client's First Name _____ Middle Initial _____

Do you have a twin? Yes No

Maiden Name / Other Names or Aliases _____

Physical Address _____ City / State / ZIP _____ County _____

Mailing Address _____ City / State / ZIP _____ County _____

Email Address _____

Home Phone _____ Mobile Can we leave a message? Voice Text

Work Phone _____ Mobile Can we leave a message? Voice Text

Social Security Number _____ Date of Birth _____ Mother's First Name _____

Place of Birth: City / State / County or Country _____

Gender: Male Female Other _____

Marital Status: Never Married Now Married Divorced Widowed Minor Child

Race: African American Asian Caucasian Native American Hispanic
 Native Hawaiian/Other Pacific Islander Other More than One

Hispanic Origin: Not Hispanic Cuban Other Hispanic Mexican Puerto Rican

Employment Status: Employed - Less than 30 hrs/wk Employed - More than 30 hrs/wk
 Unemployed Unemployed - Disabled Homemaker Retired
 Child (0-15 yrs) Student (16+ yrs) Inmate Volunteer

Residential Status:
 Lack a fixed, regular residence (includes shelters, transitional housing, street, vehicle, staying with friends/relatives)
 Private Residence / Household Group Home Residential Treatment Foster Home
 Jail Other Residential Setting Unknown

Primary Language: English Spanish Sign Language Other: _____
Will you require translation services? Yes No

Veteran Status: Not a Veteran Non-Combat Veteran Combat Veteran

Have you seen your primary care doctor in the last year? Yes No Date: _____

Last Grade of School Completed: _____
If a minor child, have they attended school in the last three (3) months? Yes No
If a minor child, have they been suspended from school in the last three (3) months? Yes No

FREMONT COUNSELING SERVICE

Have you used tobacco in the last 30 days:

- Never Used Yes (Traditional cigarettes/cigars/pipes) No
- Snuff/chew More than one form of tobacco E-Cigarettes

Have you been arrested in the last 90 days? Yes No **Are you currently on** Probation Parole?

Have you attended an AA/NA (or other social support group) in the last 30 days? Yes No

Who referred you to us?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Family / Friends | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> School |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Other MD | <input type="checkbox"/> Other Private MH Provider | <input type="checkbox"/> Wyoming State Hospital |
| <input type="checkbox"/> DVR | <input type="checkbox"/> Employer | <input type="checkbox"/> Drug / Alcohol Treatment | <input type="checkbox"/> Drug Court |
| <input type="checkbox"/> DFS | <input type="checkbox"/> CDS / Head Start | <input type="checkbox"/> Juvenile Probation – DFS | <input type="checkbox"/> Medical Hospital |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Shelter | <input type="checkbox"/> Veterans Affairs | <input type="checkbox"/> Adult Probation/Parole |
| <input type="checkbox"/> Other | <input type="checkbox"/> Clergy | <input type="checkbox"/> Other MH Center | <input type="checkbox"/> Court |
| <input type="checkbox"/> Private Psychiatrist | <input type="checkbox"/> CES / WLRC | <input type="checkbox"/> Dept. of Corrections | <input type="checkbox"/> Other Inpatient Treatment |

If self-referred, how did you hear about us?

- Internet Search Newspaper Radio TV Other: _____

EMERGENCY CONTACT

Name _____ **Address / City / State / ZIP** _____ **Phone Number** _____

Relationship:

- Spouse / Domestic Partner Sibling Parent / Foster Parent / Grandparent Child Friend Guardian / Legal Representative

LEGAL STATUS

- Adult, no Guardian Adult, has Guardian Minor, has Guardian Minor, Emancipated

Guardian's Name _____ **Address / City / State / ZIP** _____ **Phone Number** _____

Relationship:

- Spouse / Domestic Partner Sibling Parent / Foster Parent / Grandparent Child Friend Guardian / Legal Representative

TOTAL ANNUAL HOUSEHOLD INCOME: \$ _____ **Total People in Household:** _____

Primary Income Source:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Self | <input type="checkbox"/> Family (Parent/Guardian/Spouse/Adult Children) | <input type="checkbox"/> Retirement |
| <input type="checkbox"/> DFS / Welfare | <input type="checkbox"/> SSI (Supplemental Security Income) | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Other Disability | <input type="checkbox"/> SSDI (Social Security Disability Income) | <input type="checkbox"/> Other |

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES

Responsible Person's Name _____ Social Security Number _____ Date of Birth _____

Address _____ City / State / ZIP _____ Phone Number _____ Relationship to Client _____

Insurance Company _____ Policy/Group ID Number _____ Copay Amount _____

Please present your insurance card to the front desk at check in. No Insurance

Signature of Person Completing Form

Date

FREMONT COUNSELING SERVICE

Intake Form

Name: _____ Age: _____ Date: _____

All responses to these questions are kept strictly confidential and are included in your clinical record.

PRESENTING PROBLEMS AND CONCERNS

Please describe the problem that brought you here today: _____

Please check all of the behaviors and symptoms that you consider to be problematic for you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Suspicion/paranoia |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Wide mood swings |
| <input type="checkbox"/> Poor memory/confusion | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Seasonal mood changes | <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Loss of pleasure/interest | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Thoughts of death/suicide | <input type="checkbox"/> Aggression/fights | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Self-harming behaviors | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Parenting problems |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Guilt/shame | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Visual hallucinations | <input type="checkbox"/> Recurring, disturbing memories |
| <input type="checkbox"/> Other: _____ | | |

Are your problems affecting any of the following?

- | | | | |
|--|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/school | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Health | <input type="checkbox"/> Sexual Activities | |

Please note if you have experienced or witnessed any of the following types of trauma or loss:

- | | | |
|---|---|---|
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Neglect | <input type="checkbox"/> Lived in a foster home |
| <input type="checkbox"/> Terrorism | <input type="checkbox"/> Combat Veteran | <input type="checkbox"/> Natural disaster |
| <input type="checkbox"/> Sexual abuse/assault | <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Multiple family moves |
| <input type="checkbox"/> Physical abuse/assault | <input type="checkbox"/> Crime victim | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Parent substance abuse | <input type="checkbox"/> Significant parent illness | <input type="checkbox"/> Loss of a loved one |
| <input type="checkbox"/> Teen/unplanned pregnancy | <input type="checkbox"/> Place a child for adoption | <input type="checkbox"/> Financial problems |

Other: _____

PREVIOUS MENTAL HEALTH TREATMENT

Have you had any previous mental health or substance use treatment?

YES	When?	Where?	Reason for Treatment?
<input type="checkbox"/>	Outpatient counseling		
<input type="checkbox"/>	Medication		
<input type="checkbox"/>	Psychiatric hospitalization		
<input type="checkbox"/>	Drug/alcohol treatment		
<input type="checkbox"/>	Self-help/support groups		

SUBSTANCE USE HISTORY

Do you use or have you used:	How often?	How much?	Age of first use?
<input type="checkbox"/> Tobacco <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Caffeine <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Alcohol <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Marijuana <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Cocaine/crack <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Ecstasy <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Heroin <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Inhalants <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Meth <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Rx Pain Killers <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> PCP/LSD <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> Steroids / Tranquilizers <input type="checkbox"/> Current <input type="checkbox"/> Past			
<input type="checkbox"/> OTHER:			
<input type="checkbox"/> OTHER:			

Have you ever had withdrawal symptoms when trying to stop taking any substances? Yes No
If yes, please describe: _____

Have you ever had problems with work, relationships, the law, etc. due to substance use? Yes No
If yes, please describe: _____

FAMILY AND DEVELOPMENTAL HISTORY

	Maternal (Mother's Side)	WHO?	Paternal (Father's Side)
Family Mental Health Problems	<input type="checkbox"/>		<input type="checkbox"/>
Sexually Abused	<input type="checkbox"/>		<input type="checkbox"/>
Depression	<input type="checkbox"/>		<input type="checkbox"/>
Suicide	<input type="checkbox"/>		<input type="checkbox"/>
Anxiety/Panic Attacks	<input type="checkbox"/>		<input type="checkbox"/>
Anger/Abusive	<input type="checkbox"/>		<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>		<input type="checkbox"/>
OTHER:	<input type="checkbox"/>		<input type="checkbox"/>
OTHER:	<input type="checkbox"/>		<input type="checkbox"/>
OTHER:	<input type="checkbox"/>		<input type="checkbox"/>
OTHER:	<input type="checkbox"/>		<input type="checkbox"/>

Are your parents: Legally married or living together? Mother remarried: _____ number of times
 Temporarily separated? Father remarried: _____ number of times
 Divorced or permanently separated?

What is the quality of your relationship with your:

Mother	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> No Relationship	<input type="checkbox"/> Other: _____
Father	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> No Relationship	<input type="checkbox"/> Other: _____
Step-Mother	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> No Relationship	<input type="checkbox"/> Other: _____
Step-Father	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> No Relationship	<input type="checkbox"/> Other: _____
Brothers/Sisters	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> No Relationship	<input type="checkbox"/> Other: _____
Spouse/Partner	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> No Relationship	<input type="checkbox"/> Other: _____
Children	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> No Relationship	<input type="checkbox"/> Other: _____

INTERPERSONAL / SOCIAL / CULTURAL INFORMATION

Who would you include in your social support network?

Family Neighbors Friends Students
 Co-workers Community group Support/Self-help group
 Religious/spiritual center (which one)? _____

How important are spiritual matters to you? Very Somewhat Not at all

Do you live by yourself or with others? With who? _____

How long have you been in your current living situation? _____

Do you identify with a particular ethnic or cultural group? Which one(s)? _____

Are ethnic or cultural issues causing difficulty in your life? Please describe: _____

What gender do you identify with: Male Female Neither Other: _____

What is your sexual orientation: Straight Gay/Lesbian Bi-sexual Other: _____

FREMONT COUNSELING SERVICE
Child/Youth Intake – Additional Questions

Child's Name _____

Age _____

All responses to these questions are kept strictly confidential.

CUSTODIAL STATUS

Who has legal custody of the child? _____

Who has parental rights of the child?

Mother Yes No
Father Yes No

Who has physical custody of the child? _____

DEVELOPMENTAL HISTORY

Were there complications with this pregnancy? Yes No Unknown
Did the mother sustain any major illness/injury while pregnant? Yes No Unknown

During the pregnancy, did the mother use:

Tobacco? Yes No Unknown
Alcohol? Yes No Unknown
Prescription drugs? Yes No Unknown
Other substances? Yes No Unknown

Was delivery: Early Normal Late Unknown
Were there any complications with/labor delivery? Yes No Unknown

When the child was an infant were they:

Easy to comfort? Yes No Unknown
Quiet? Yes No Unknown
Excessively irritable? Yes No Unknown
Prone to temper tantrums? Yes No Unknown
Quick to anger? Yes No Unknown
An excessive climber? Yes No Unknown
Resistant to physical contact? Yes No Unknown
Sleep too much / too little? Yes No Unknown
Eat too much / too little? Yes No Unknown
Eat things that were not food? Yes No Unknown

Developmental Milestones:

Gross motor? Early Average Delayed Unknown
Fine motor? Early Average Delayed Unknown
Social skills? Early Average Delayed Unknown

Speech functioning? Normal Some Problems Requires Assistance Should be Evaluated
Hearing functioning? Normal Some Problems Requires Assistance Should be Evaluated
Visual functioning? Normal Some Problems Requires Assistance Should be Evaluated

Are the child's immunizations up to date? Yes No Unknown

Is the child able to form and maintain relationships? Yes No Unknown

Is the child's housing situation stable? Yes No Unknown

Is the child at risk for an out-of-home placement? Yes No Unknown

Current school, grade, and teacher name (if known), OR current day/childcare situation:

Does the child have an IEP or MDT in place? Yes No Unknown

Does the child have behavior problems at school / daycare? Yes No Unknown

Has the child had any educational evaluations? Yes No Unknown

How does the child's intellectual functioning appear? Below Average Average Above Average

PARENT/GUARDIAN INVOLVEMENT

Are you (as the child's parent/guardian) able and willing to participate in the child's services as indicated?

Yes No

Please describe any special areas of interest, hobbies of the parent/guardian, or other things that the parent/guardian enjoys:

Do you have any needs or preferences for the treatment/services that your child receives? (For example: male or female clinician? How often would you like your child to be seen? Day/afternoon/evening appointments?)

What is your goal for treatment of your child? What do you hope to accomplish by your child receiving services from us?

Parent/Guardian Signature

Date

Patient Health Questionnaire-Modified for Teens

Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, irritable or hopeless?	0	1	2	3
3. Trouble falling asleep, or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite, weight loss, or overeating?	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0 + + +
= Total Score

10. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
11. In the <i>past year</i> , have you felt depressed or sad most days, even if you felt OK sometimes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
12. Has there been a time in the <i>past month</i> when you have had serious thoughts about ending your life?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
13. Have you <i>ever, in your whole life</i> , tried to kill yourself or made a suicide attempt?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		