

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: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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, or hopeless	0	1	2	3
3. Trouble falling 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 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, such as reading the newspaper or watching television	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	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

<p>10. If you checked off <i>any problems</i>, 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?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (<i>add your column scores</i>) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
 Somewhat difficult _____
 Very difficult _____
 Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.