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

☐ Mobile **Can we leave a message?** ☐Voice ☐Text

Home Phone

☐ Mobile **Can we leave a message?** ☐Voice ☐Text

Work Phone

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?

☐ Self	☐ Family / Friends	☐ Law Enforcement	☐ School
☐ Attorney	☐ Other MD	☐ Other Private MH Provider	☐ Wyoming State Hospital
☐ DVR	☐ Employer	☐ Drug / Alcohol Treatment	☐ Drug Court
☐ DFS	☐ CDS / Head Start	☐ Juvenile Probation – DFS	☐ Medical Hospital
☐ Nursing Home	☐ Shelter	☐ Veterans Affairs	☐ Adult Probation/Parole
☐ Other	☐ Clergy	☐ Other MH Center	☐ Court
☐ Private Psychiatrist	☐ CES / WLRC	☐ Dept. of Corrections	☐ 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:

☐ Self	☐ Family (Parent/Guardian/Spouse/Adult Children	☐ Retirement
☐ DFS / Welfare	☐ SSI (Supplemental Security Income)	☐ Unemployment
☐ Other Disability	☐ SSDI (Social Security Disability Income)	☐ 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:

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

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/school
- ☐ Recreational Activities
- ☐ Self-esteem
- ☐ Housing
- ☐ Health
- ☐ Relationships
- ☐ Legal matters
- ☐ Sexual Activities
- ☐ Hygiene
- ☐ Finances

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

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

☐ Other: _____

PREVIOUS MENTAL HEALTH TREATMENT

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

YES	When?	Where?	Reason for Treatment?
☐ Outpatient counseling			
☐ Medication			
☐ Psychiatric hospitalization			
☐ Drug/alcohol treatment			
☐ Self-help/support groups			

SUBSTANCE USE HISTORY

Do you use or have you used:		How often?	How much?	Age of first use?
☐ Tobacco	☐ Current ☐ Past			
☐ Caffeine	☐ Current ☐ Past			
☐ Alcohol	☐ Current ☐ Past			
☐ Marijuana	☐ Current ☐ Past			
☐ Cocaine/crack	☐ Current ☐ Past			
☐ Ecstasy	☐ Current ☐ Past			
☐ Heroin	☐ Current ☐ Past			
☐ Inhalants	☐ Current ☐ Past			
☐ Meth	☐ Current ☐ Past			
☐ Rx Pain Killers	☐ Current ☐ Past			
☐ PCP/LSD	☐ Current ☐ Past			
☐ Steroids / Tranquilizers	☐ Current ☐ Past			
☐ OTHER:				
☐ 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	☐		☐
Sexually Abused	☐		☐
Depression	☐		☐
Suicide	☐		☐
Anxiety/Panic Attacks	☐		☐
Anger/Abusive	☐		☐
Alcohol/Drug Abuse	☐		☐
OTHER:	☐		☐
OTHER:	☐		☐
OTHER:	☐		☐
OTHER:	☐		☐

Are your parents: ☐Legally married or living together? ☐Temporarily separated? ☐Divorced or permanently separated?

Mother remarried: _____ number of times

Father remarried: _____ number of times

What is the quality of your relationship with your:

Mother	☐Good	☐Poor	☐No Relationship	☐Other:_____
Father	☐Good	☐Poor	☐No Relationship	☐Other:_____
Step-Mother	☐Good	☐Poor	☐No Relationship	☐Other:_____
Step-Father	☐Good	☐Poor	☐No Relationship	☐Other:_____
Brothers/Sisters	☐Good	☐Poor	☐No Relationship	☐Other:_____
Spouse/Partner	☐Good	☐Poor	☐No Relationship	☐Other:_____
Children	☐Good	☐Poor	☐No Relationship	☐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: _____

LEGAL INFORMATION

Have you ever been convicted of a misdemeanor or felony? ☐Yes ☐No

If yes, please describe: _____

Are you currently involved in any divorce and/or child custody proceedings? ☐Yes ☐No

If yes, please describe: _____

MEDICAL INFORMATION

_____

Date of last exam/treatment by a physician — Reason for last exam/treatment

_____

Physician (Name / Phone Number) — Psychiatrist (Name / Phone Number)

_____

Pharmacy / Location

Drug Allergies: _____

Do you have any psychiatric Advance Directives? ☐Yes ☐No (If yes, was a copy provided?)
Would you like more information on psychiatric Advance Directives? ☐Yes ☐No

MEDICATION INFORMATION

Please include prescription medications as well as over-the-counter (OTC) medications, herbal supplements, vitamins, etc. If you need more space for more medications, please let reception know.

Medication Name	How much and How often?	Do they help? Any side effects/bad reactions?	Prescriber

_____

Signature — Date

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 *last 2 weeks*, 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 ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐
11. In the ***past year***, have you felt depressed or sad most days, even if you felt OK sometimes?	Yes ☐	No ☐		
12. Has there been a time in the ***past month*** when you have had serious thoughts about ending your life?	Yes ☐	No ☐		
13. Have you ***ever, in your whole life***, tried to kill yourself or made a suicide attempt?	Yes ☐	No ☐		

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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 Inern Med.* 2006;166:1092-1097.