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SPEAK LIFE
Renewing minds. Healing hearts.

For office use only
Intake DOS

Client Full Name_____ **Date of Birth**_____

Today's Date_____

This form is subject to the Privacy Act of 1974, it is designed to help SPEAK LIFE develop a treatment plan that meets your needs.

PRESENTING CONCERN

Briefly describe your main concern(s)_____

_____

SAFETY ISSUES

Has your current condition made you so distressed that you have had thoughts of ending your life?

If YES, how likely are you to carry it out?

Not likely 1 2 3 4 Very likely

Have you ever tried to intentionally hurt or kill yourself?

If YES, how severe were the injuries?

Not severe 1 2 3 4 Very severe

Has your current condition made you so distressed that you have had thoughts of hurting someone else?

If YES, how likely are you to carry it out?

Not likely 1 2 3 4 Very likely

BACKGROUND INFORMATION

Social Support / Spirituality
How important is the spiritual dimension of your life? Not Important 0 1 2 3 4 Very Important

How much is your spiritual community a source of support for you? No Support ○ ○ ○ ○ ◉ Very Supportive

If so, what faith community are you a part of?_____

Does your spiritual life help you cope with your struggles?_____

History of Present Problem (symptoms, onset, duration, frequency, etc.)_____

_____

Client Full Name_____ **DOB**_____

BACKGROUND INFORMATION CONTINUED

Past Psychiatric History (prior treatment, symptoms, diagnoses, hospitalization, suicide attempts, self-injury behaviors, violent history, etc.)_____

_____

Trauma History (nature of trauma, when occurred, persons involved, etc.)_____

_____

Please check any of the following events that applied to you in the past:

☐ Death of someone close	☐ Physical abuse	☐ Natural disaster	☐ War
☐ Unhappy childhood	☐ Abusive relationship	☐ Emotional abuse	☐ Crime victim
☐ Sexual abuse	☐ Sexual assault	☐ Filed for bankruptcy	☐ Chaotic environment

Family Psychiatric History (history of mental illness in family, diagnoses, etc.)_____

_____

MEDICAL & HEALTH INFORMATION

Medical Conditions & History (current and past medical conditions, treatments, allergies, etc.)_____

_____

Present overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Medications (dosage, purpose, prescribing physician)_____

_____

Substance Use (substance start date, last use, amount, frequency, etc.)_____

_____

Do you use tobacco products? ☐ Yes ☐ No If yes, please specify type_____

Do you drink alcoholic beverages? ☐ Yes ☐ No How much?_____ How often?_____

Have you ever felt bad or guilty about your drinking behaviors?_____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, please specify type & amount_____

Do you exercise regularly? ☐ Yes ☐ No If yes, please specify_____

Client Full Name_____ **DOB**_____

FAMILY HISTORY INFORMATION

Family History (family of origin, relationship with parents, siblings, significant other(s))_____

Who were you mostly raised by?

☐ Both parents ☐ Father ☐ Foster parents ☐ Other (please specify)
☐ Mother ☐ Step-parent ☐ Adoptive parents _____

Social History (significant relationships, social support, nature/quality of relationships, etc.)_____

How many marriages total? _____ Divorces?_____ Length of current marriage?_____

How satisfied are you with your current family life?

☐ Very unsatisfied ☐ Unsatisfied ☐ Satisfied ☐ Very satisfied

Please list all your children

Name	Sex	Age	Living with you
_____	☐ M ☐ F	_____	◯ Yes ◉ No
_____	☐ M ☐ F	_____	◯ Yes ◉ No
_____	☐ M ☐ F	_____	◉ Yes ◯ No
_____	☐ M ☐ F	_____	◯ Yes ◉ No

Any major concerns or significant problems with your children?_____

Personal Developmental History (developmental milestones, delays, etc.)_____

EDUCATIONAL / OCCUPATIONAL INFORMATION

Educational / Occupational History

Highest level of education completed? ◉ GED ◯ HS ◯ Some College ◯ Associate ◯ Bachelors ◯ Graduate

Current employer_____ Length of time_____ Position_____

Are you having any difficulties with your job? If yes, please describe_____

Do you believe your current problems are related to your job?_____

Client Full Name_____ **DOB**_____

OTHER INFORMATION

Do you have any current financial concerns? If yes, please describe_____

_____

Legal History (arrest history, sentencing, DUI occurrences, incarceration, litigation)_____

_____

Do you have any recent or current legal problems? If yes, please describe_____

_____

Strengths / Limitations_____

_____

Other information that you feel is important for us to know about you or your current situation_____

_____

Client Full Name_____ **DOB**_____

CONCERNS CHECKLIST (CHECK ALL THAT APPLY)

____ Depression
____ Low energy
____ Poor concentration
____ Lack of interest/enjoyment in life
____ Feeling hopeless
____ Feeling worthless
____ Feeling guilty or shameful
____ Sleep changes (more/less)
____ Loneliness
____ Bad dreams/nightmares
____ Feeling ignored or abandoned
____ Appetite changes (more/less)
____ Mood swings
____ Thoughts of hurting self
____ Thoughts of hurting others
____ Isolating from others/social withdrawal
____ Feelings of sadness/loss
____ Weight problems
____ Stress
____ Anxiety/tension/worry
____ Panic attacks
____ Heart racing
____ Chest pain or heaviness
____ Chills/hot flashes
____ Tingling/numbness
____ Pain
____ Fear of dying
____ Fear of going "crazy"
____ Nausea
____ Fears or phobias
____ Obsessions/compulsions
____ Thoughts racing
____ Disorganization
____ Procrastination
____ Can't hold onto an idea
____ Anger/frustration
____ Suspiciousness or mistrustfulness
____ Problems trusting others
____ Easily irritated/annoyed
____ Aggressiveness
____ Perfectionist behavior
____ Lying
____ Making/keeping friends
____ Arguing with others
____ Performing unusual rituals or habits
____ Impulsiveness
____ Excessive behaviors (spending, gambling, etc.)
____ Delusions/hallucinations
____ Sexual problems
____ Self-injurious behaviors
____ Shyness
____ Social support (family/friends)
____ Stealing
____ Strange, weird, or peculiar behavior
____ Alcohol abuse
____ Alcohol use
____ Drug abuse
____ Drug use
____ Confusion/can't think clearly
____ Feeling "not real"
____ Feeling detached from yourself
____ Feeling "hyper"
____ Financial problems
____ Grief/bereavement
____ Health problems
____ Impact of your problems on others
____ Losing track of time
____ Problems with memory
____ Unpleasant thoughts that won't go away
____ Bothered by recurring thoughts
____ Job/Career problems or indecision
____ Destruction of property
____ Self-criticism
____ Family problems
____ Marital/Relationship problems
____ Blackouts
____ Physical abuse
____ Sexual abuse
____ Partner abuse
____ Trouble with the law
____ Experienced/Witnessed trauma
____ Loss/Death of someone close
Other_____
_____