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For office use only
 Intake DOS

Minor 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.

***** Parent/Guardian, please complete this form with your child's input *****

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				Very likely
1	2	3	4	

Have you ever tried to intentionally hurt or kill yourself?

If YES, how severe were the injuries?

Not severe			Very severe
1	2	3	4

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				Very likely
1	2	3	4	

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	0	1	2	3 4 Very Supportive
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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.) _____

Minor 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 _____

Minor 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 satisfied are you with your current family life?

- Very unsatisfied Unsatisfied Satisfied Very satisfied

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

EDUCATIONAL / OCCUPATIONAL INFORMATION

Are you a full-time or part-time student? _____

If not in school, please explain circumstances _____

Current grade _____ Name of School _____

Are you having any difficulties in school? If yes, please describe _____

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? _____

Minor 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 _____

Minor Client Full Name _____ DOB _____

CONCERNS CHECKLIST (CHECK ALL THAT APPLY)

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