Centers for Motivation, Inc.

INTAKE QUESTIONNAIRE

Client Information

Date: ______________________

Name: ______________________

Address: ______________________

DOB: ______________________

City: ______________________

State: __________

Gender: ☐ **Male** ☐ **Female**

Zip: __________

Phone: ______________________

Alt. Phone: ______________________

E-mail: ______________________

Soc. Sec.#: ______________________

Marital Status:
☐ **Single**
☐ **Married** how long? ________
☐ **Separated** how long? ________
☐ **Divorced** how long? ________
☐ **Widowed** how long? ________

What problem or issue would you like to change?

How long has this been a problem?

What is the first time that you remember this being an issue?

Describe what happens hours or minutes before this event occurs.

Describe your thoughts, feelings and behaviors at the time of the event.

Describe your thoughts, feelings and behaviors after the event.

Describe how your life would be, over the next few years, if you did nothing about this problem.

If you could permanently fix this issue, what value would you place on that change? ________

Client Name:

Do you suffer from any of the following sympoms? (check all that apply)

- ☐ chronic sadness
- ☐ crying episodes
- ☐ hopelessness
- ☐ difficulty concentrating
- ☐ rapid weight loss
- ☐ rapid weight gain
- ☐ loss of appetite
- ☐ overeating
- ☐ nausea/vomiting
- ☐ difficulty making decisions
- ☐ recurring thoughts of death/dying
- ☐ depressed mood
- ☐ decreased energy
- ☐ grief
- ☐ guilt
- ☐ low frustration tolerance
- ☐ irritability
- ☐ difficulty falling asleep
- ☐ difficulty staying asleep
- ☐ early morning awakening
- ☐ memory problems
- ☐ suicidal thoughts
- ☐ suicide attempt
- ☐ withrdrawl from others
- ☐ difficulty functioning at work
- ☐ difficulty functioning socially
- ☐ low energy/fatigue
- ☐ reduced interest/pleasure
- ☐ worthlessness

- ☐ agitation
- ☐ restlessness
- ☐ excessive worry
- ☐ fearfulness
- ☐ trembling/shaking
- ☐ fear of loss of control
- ☐ fear of dying
- ☐ difficulty relaxing
- ☐ panic attacks
- ☐ fear of leaving home
- ☐ avoidance of public places
- ☐ avoidance of social situations
- ☐ pounding heart/palpitations/shortness of breath
- ☐ chest pain
- ☐ anxiety

- ☐ feeling detached from others/life
- ☐ intrusive thoughts of bad memories
- ☐ nightmares
- ☐ flashbacks/re-living bad experiences
- ☐ easily startled/upset

- ☐ excessive eating
- ☐ underweight
- ☐ abuse of laxitives
- ☐ eating problems interfering with health
- ☐ obesity
- ☐ self-induced vomiting
- ☐ obessing about food, diet, exercise
- ☐ exhaustion

- ☐ hearing voices others do not hear
- ☐ fearful others are talking about you
- ☐ paranoia
- ☐ fixed false beliefs
- ☐ hallucinations
- ☐ intrusive thoughts
- ☐ disorientation
- ☐ seeing things others do not see
- ☐ fearful someone is plotting against you
- ☐ unaware of surroundings
- ☐ disrupted thoughts
- ☐ racing thoughts
- ☐ thought disorder
- ☐ problems with judgment/planning

- ☐ difficulty completing task/distractible
- ☐ difficulty focusing
- ☐ impulsiveness
- ☐ not well organized
- ☐ short attention span
- ☐ frequent forgetfulness
- ☐ difficulty waiting your turn
- ☐ inability to concentrate
- ☐ hyperactivity
- ☐ problem with following instructions

- ☐ oppositional/defiant behavior
- ☐ problems with peers
- ☐ involved in criminal justice system
- ☐ fire setting
- ☐ high risk sexual behavior
- ☐ problems with legal authorities
- ☐ inability to control temper
- ☐ aggression/violent behavior
- ☐ torturing animals
- ☐ stealing

- ☐ lying
- ☐ self-mutilation
- ☐ talks excessively
- ☐ elopement from home
- ☐ uncooperative
- ☐ minimal talk

Career / Work Problems:

- ☐ have trouble remembering
- ☐ difficulty with problem solving
- ☐ become agitated when confronted with problems
- ☐ difficulty with decision making
- ☐ handle expectations poorly
- ☐ difficulty thinking through consequences
- ☐ discourteous
- ☐ shy/withdrawn from coworkers
- ☐ aggressive toward coworkers
- ☐ try to interact but do so inappropriately
- ☐ frequent reprimands/writeups
- ☐ reading/writing difficulty
- ☐ test/evaluation anxiety
- ☐ reversing words or numbers
- ☐ lose track of time
- ☐ forgetting recent events
- ☐ unable to stay on task
- ☐ trouble shifting tasks
- ☐ difficulty learning new tasks
- ☐ too hyperactive to concentrate
- ☐ feeling isolated from coworker/supervisor supports
- ☐ oppositional/defiant to authority figures
- ☐ exhibiting bizarre behaviors (if yes, specify below)
- ☐ impulsivity
- ☐ truancy
- ☐ low self esteem regarding abilities
- ☐ slow to finish work
- ☐ do not complete work

☐ Additional comments:

Current Career / Employment:

Other Problem Areas:

- ☐ obsessive behavior
- ☐ elevated mood
- ☐ somatic complaints
- ☐ victim of sexual abuse
- ☐ victim of neglect
- ☐ victim of physical abuse
- ☐ victim of emotional trauma
- ☐ gambling
- ☐ confused/worried about sexual behavior
- ☐ dizziness/blackouts
- ☐ alcohol use/abuse
- ☐ drug use/abuse
- ☐ learning disability
- ☐ bed wetting past age 6
- ☐ developmental disability/MR
- ☐ smoking
- ☐ excessive spending
- ☐ parent-child conflict
- ☐ staying up for days without sleep

Strengths

- ☐ creative
- ☐ artistic
- ☐ athletic
- ☐ entrepreneurial
- ☐ street-wise
- ☐ common sense
- ☐ outgoing
- ☐ intelligent
- ☐ musical talent
- ☐ positive interactions with family
- ☐ positive interactions with peers
- ☐ positive attitude
- ☐ friendly
- ☐ leader
- ☐ enjoy reading
- ☐ enjoy writing
- ☐ active in community
- ☐ team sports
- ☐ active in other activities
- ☐ physically fit
- ☐ confident
- ☐ humorous

- ☐ independent
- ☐ self-directed
- ☐ emotionally stable
- ☐ academic acheiver
- ☐ orderly
- ☐ helpful
- ☐ hobbies/interests (list):

Current general medical conditions (check all that apply):

- ☐ hypertension
- ☐ heart disease
- ☐ cardiac (other)
- ☐ asthma
- ☐ HIV
- ☐ allergies (if yes, explain below)
- ☐ hypothyroidism
- ☐ other significant systemic illness (specify)
- ☐ diabetes
- ☐ endocrine (other)
- ☐ cancer
- ☐ seizure disorder
- ☐ stroke
- ☐ neurological (other)
- ☐ chronic lung disorder

- ☐ Additional comments:

Has there been a history of any of the following:

- ☐ head injury
- ☐ illness
- ☐ surgery
- ☐ anethetics
- ☐ high fever
- ☐ loss of consciousness
- ☐ poisoning
- ☐ personality changes

details:

Primary Care Physician Information

Name ____________________

Address ____________________

____

Phone ____________________

Have you been on any medications for behavioral/psychiatric treatment in the past?

Medication	Dosage	Duration

Previous Treatment:

☐ Psychiatric Hospitalization	If yes, date(s)	
☐ Individual Therapy	If yes, date(s)	
☐ Group Therapy	If yes, date(s)	
☐ Family Therapy	If yes, date(s)	
☐ Residential Treatment	If yes, date(s)	

Was your birth unusual in any way (premature, lack of oxygen)?

If yes, in what way? ______________________

Is there a family history of any of the following:

- ☐ Depression
- ☐ Schizophrenia
- ☐ Bipolar Disorder (Manic-Depression)
- ☐ Anxiety Disorder
- ☐ Drug abuse
- ☐ Gambling
- ☐ Incarceration
- ☐ Domestic violence
- ☐ Other mental illness
- ☐ Suicide
- ☐ Alcohol abuse
- ☐ Sexual abuse

Who in the family has the above history?

Father ______________________
Mother ______________________
Sibling(s) ______________________

Grandfather (paternal) ______________________
Grandmother (paternal) ______________________
Uncle/Aunt (paternal) ______________________

Grandfather (maternal) ______________________
Grandmother (maternal) ______________________
Uncle/Aunt (maternal) ______________________

Your Education

- ☐ Some high school
- ☐ High school graduate
- ☐ Some college
- ☐ College graduate
- ☐ Graduate degree

Job/Profession

Learning difficulties (specify)

Your Parents' Education:

Father ______________ Profession: ______________
Mother ______________ Profession: ______________

Do you have children? If yes, how many? Ages?

____

Do you have any siblings? If yes, how many? Ages?

____

Client Name:

Comments

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