



## Integrated Care Concepts and Consultation

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This confidential, multi-faceted, intake form helps us understand different parts and pieces to who you are as a person. Although some questions may seem irrelevant to your care, they will play a role in our core understanding of current and past issues and help us build and develop an integrative treatment plan.

### Client Information

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Client Name: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we email you? \_\_\_\_\_

Emergency Name and Contact Number: \_\_\_\_\_

### Counseling Information

Please describe the difficulties you are having that have brought you to our office: \_\_\_\_\_

\_\_\_\_\_

What has contributed to these difficulties? \_\_\_\_\_

\_\_\_\_\_

What are your goals in seeking treatment at our office? \_\_\_\_\_

\_\_\_\_\_

Have you been in treatment with a psychologist or psychiatrist before and if so for what? \_\_\_\_\_

\_\_\_\_\_ How long were you in treatment before: \_\_\_\_\_

What was the name of your prior counselor? \_\_\_\_\_

What else would be helpful for us to know: \_\_\_\_\_

Have you experienced any significant trauma or loss in your life, and if applicable, please indicate what and when: \_\_\_\_\_

What would you say is the main barrier(s) in allowing you live the life you desire? \_\_\_\_\_

How would you describe your life's purpose: \_\_\_\_\_

Please list 1-3 qualities, behaviors or characteristics that you would like to change or enhance within one year's time: \_\_\_\_\_

### Employment Information

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

How would you rate your enjoyment of your job: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What about your job do you enjoy? \_\_\_\_\_

What about your job do you dislike? \_\_\_\_\_

What is your dream job? \_\_\_\_\_

### Educational Background/Information

School: \_\_\_\_\_ School Address: \_\_\_\_\_

Date you graduated or expect to graduate: \_\_\_\_\_

What are you studying? \_\_\_\_\_

What are your educational goals? \_\_\_\_\_

### Family Information

Marital Status: Single Married Divorced Separated Widowed Committed-Relationship

How many people live in your household: \_\_\_\_\_ Do you live with a roommate? \_\_\_\_\_

Do you have children? \_\_\_\_\_ If so, what are your children's names and ages? \_\_\_\_\_

Do you live in a group home or residential treatment center? \_\_\_\_\_

Are you part of a blended/step-family? \_\_\_\_\_

Will other friends or family members be participating in your counseling? \_\_\_\_\_

If so, who will be participating: \_\_\_\_\_

If you are in a romantic relationship, how would you rate your relationship with your partner?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your communication level with your partner?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your communication level with other family members?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

Do you have any pets, and if so, what type? \_\_\_\_\_

Who would you indicate as the main person who supports you emotionally: \_\_\_\_\_

### Health Information

Are you currently under the care of a physician for any medical issue(s), and if so, please indicate: \_\_\_\_\_

Are you currently taking any prescribed medications, and if so, what:

Have you ever been treated or hospitalized for a psychiatric condition, suicide, drug/alcohol/substance abuse issue? \_\_\_\_\_

Does anyone in your family have a mental or psychiatric condition? \_\_\_\_\_

Have you ever been diagnosed with Bi-Polar Disorder? If so, when? \_\_\_\_\_

How would you rate your energy level in the past 4 weeks?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current physical health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current emotional health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your general happiness and wellbeing?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

In the past 4 weeks how would you rate your ability in being able to relax?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current stress level?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

What would you indicate are major stressors in your life? \_\_\_\_\_

What are some ways that you have found are effective in helping you relieve stress? \_\_\_\_\_

How well do you nourish yourself with healthy/balanced food?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with love/laughter?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with words of self-encouragement?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with self-care?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

What was the last book you read? \_\_\_\_\_

Who are some of your favorite musicians: \_\_\_\_\_

What do you do to have fun? \_\_\_\_\_

Do you currently take any nutritional supplements, vitamins, herbals, essential oils: \_\_\_\_\_

Do you have any difficulty falling asleep or staying asleep? \_\_\_\_\_

About how many hours of sleep do you average per night? \_\_\_\_\_

Do you awaken from sleep feeling rested? \_\_\_\_\_

Do you participate in any type of exercise activity, and if so, what and how often? \_\_\_\_\_

Have you ever practiced Yoga? \_\_\_\_\_ If so, what was your experience like? \_\_\_\_\_

Have you ever practiced Meditation? \_\_\_\_\_ If so, what was your experience like? \_\_\_\_\_

If not, what are the barriers preventing you from meditating? \_\_\_\_\_

Do you think that meditation would help you with your current issue? \_\_\_\_\_

### Depression/Anxiety Questions

In the past four weeks:

Have you had difficulty falling asleep or sleeping long? \_\_\_\_\_

Have you had an increase or decrease in appetite? \_\_\_\_\_

Have you had feelings of sadness, despair, sorrow? \_\_\_\_\_

Have you had excessive fatigue or lack of energy? \_\_\_\_\_

Have you had a lack of concentration or preoccupation with past or future life events?

Have you withdrawn from socialization and contact with others? \_\_\_\_\_

Have you felt a decrease in activities that were previously enjoyable? \_\_\_\_\_

Have you had thoughts that you would be better off dead or hurting yourself in some way?

Have you had feelings like you were letting yourself or others down? \_\_\_\_\_

Have you had feelings of depression or anxiety? \_\_\_\_\_

Have you had worrisome thoughts and an inability to control your worry? \_\_\_\_\_

Have you had feelings of being afraid that something tragic might happen? \_\_\_\_\_

In the past month, how often have you been completely unable to manage your days and activities due to preoccupation with these feelings of distraction? \_\_\_\_\_

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If you answered yes to any of the above questions, what have you tried to help yourself heal from these feelings? \_\_\_\_\_

What would you say is the major factor contributing to your feeling depressed or anxious?

When feelings of depression or anxiety come over you, where do you feel it in your body?

What do you think your body is trying to tell you? \_\_\_\_\_

### **Substance Abuse Information**

Do you feel you have a substance abuse problem (alcohol, drug, other): \_\_\_\_\_

If so, what would you describe as your substance(s) of choice:

For how long have you struggled with this issue: \_\_\_\_\_

What is the longest you have voluntarily gone without abusing this substance: \_\_\_\_\_

Does anyone in your family have a substance abuse condition? \_\_\_\_\_

### **Spiritual Information**

Do you feel connected spiritually? \_\_\_\_\_

What is your spiritual practice? \_\_\_\_\_

## Mindfulness

### FIVE FACET MINDFULNESS QUESTIONNAIRE (FFMQ)

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes *your own opinion* of what is *generally true* for you.

| 1                         | 2           | 3              | 4          | 5                         |
|---------------------------|-------------|----------------|------------|---------------------------|
| Never or very rarely true | Rarely true | Sometimes true | Often true | Very often or always true |

- 1. When I'm walking, I deliberately notice the sensations of my body moving.
- 2. I'm good at finding words to describe my feelings.
- 3. I criticize myself for having irrational or inappropriate emotions.
- 4. I perceive my feelings and emotions without having to react to them.
- 5. When I do things, my mind wanders off and I'm easily distracted.
- 6. When I take a shower or bath, I stay alert to the sensations of water on my body.
- 7. I can easily put my beliefs, opinions, and expectations into words.
- 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
- 9. I watch my feelings without getting lost in them.
- 10. I tell myself I shouldn't be feeling the way I'm feeling.
- 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
- 12. It's hard for me to find the words to describe what I'm thinking.
- 13. I am easily distracted.
- 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
- 15. I pay attention to sensations, such as the wind in my hair or sun on my face.
- 16. I have trouble thinking of the right words to express how I feel about things.
- 17. I make judgments about whether my thoughts are good or bad.
- 18. I find it difficult to stay focused on what's happening in the present.
- 19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
- 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
- 21. In difficult situations, I can pause without immediately reacting.
- 22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.
- 23. It seems I am "running on automatic" without much awareness of what I'm doing.
- 24. When I have distressing thoughts or images, I feel calm soon after.
- 25. I tell myself that I shouldn't be thinking the way I'm thinking.
- 26. I notice the smells and aromas of things.
- 27. Even when I'm feeling terribly upset, I can find a way to put it into words.
- 28. I rush through activities without being really attentive to them.
- 29. When I have distressing thoughts or images, I am able just to notice them without reacting.
- 30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.
- 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.
- 32. My natural tendency is to put my experiences into words.
- 33. When I have distressing thoughts or images, I just notice them and let them go.
- 34. I do jobs or tasks automatically without being aware of what I'm doing.
- 35. When I have distressing thoughts or images, I judge myself as good or bad depending

what the thought or image is about.

- 36. I pay attention to how my emotions affect my thoughts and behavior.
- 37. I can usually describe how I feel at the moment in considerable detail.
- 38. I find myself doing things without paying attention.
- 39. I disapprove of myself when I have irrational ideas.

**Referral Information**

Whom may we thank for referring you to our office: \_\_\_\_\_

Are you in our office for:      Referral      Employee Assistance Program      Insurance      Website  
Juvenile Court Referral      Psychiatrist Referral      Psychologist Referral      School Referral  
Hospital Referral      Other: \_\_\_\_\_

**Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
Date of Birth of Insured: \_\_\_\_\_ Insurance Name/Type: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
Insurance ID Number: \_\_\_\_\_ Group ID Number: \_\_\_\_\_

**Credit Card Information**

Please note we keep a credit card on file for no shows or for default in payment.

Credit Card Type: \_\_\_\_\_ Credit Card Code: \_\_\_\_\_  
Credit Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
Credit Card Name as it appears: \_\_\_\_\_

**Client Name/Signature/Date**

|                       |            |
|-----------------------|------------|
| Client/Guardian Name: | Signature: |
| Date:                 |            |