MINDSOURCE CENTER LLC

27023 164th Ave SE, Covington, WA 98042
Tel (253) 639-7146 Email: help@mindsourcecenter.com Fax (253) 639-7145

Client Information

Today's Date:_____

A. Basic Information

Patient Name: _____ Birthdate: _____Age: _____
Person(s) completing this form/relationship to patient: _____
Gender_____ Relationship status: ❑ Married ❑ Divorced ❑ Remarried ❑ Single, Never married
❑ Partnership ❑ Other:_____Primary Language_____
Who suggested that you come to see me? _____
Do you live with other people? ❑ No ❑ Yes, I live with (names & relationships):
_____ _____
_____ _____

B. Reason for Seeking Services

What is the main reason(s) you are requesting counseling services at this time?
_____
_____

How does this problem(s) affect your life?
_____
_____

What are your goals for treatment? Please be as specific as possible.
_____
_____

Describe what motivated you to seek therapy at this time (rather than some time earlier or later):
_____
_____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation: _____
Involvement: ❑ None ❑ Some/irregular ❑ Active
How important are spiritual concerns in your life? _____
Ethnicity/national origin or other similar way you identify yourself and consider important:
_____

D. Checklist of Concerns

To request this information in an alternative format, please contact Mindsource Center 253-639-7146. We will work with individuals requesting alternate formats, to ensure effective communication. Relay users please dial 711.

Please mark all of the items below that apply, and feel free to add any others at the bottom under “Any other concerns or issues.” You may add a note or details in the space next to the concerns checked.

❑ I have no problem or concern bringing me here
❑ Abuse—physical, sexual, emotional, neglect
❑ Aggression, violence
❑ Alcohol use
❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Confusion
❑ Custody of children
❑ Decision making, indecision, mixed feelings, putting off decisions
❑ Delusions (false ideas)
❑ Depression, low mood, sadness, crying
❑ Disability
❑ Divorce, separation
❑ Domestic violence
❑ Drug use—prescription medications, over-the-counter medications, street drugs
❑ Eating problems—overeating, undereating, appetite, vomiting
❑ Emptiness
❑ Family Stress
❑ Fatigue, tiredness, low energy
❑ Fears, phobias
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Focus, concentration
❑ Friendships
❑ Gambling
❑ Gay, Lesbian, Bisexual, Transgender concerns
❑ Grief, death, loss, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment problems, risk taking
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, dissatisfaction, infidelity/affairs
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings

Client’s name: _____ Case #: _____ Date: _____

❑ Motivation
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Personality disorder
❑ Pessimism
❑ Procrastination
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Spiritual, religious, moral, ethical issues
❑ Stress, tension, stress management
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Thought disorganization and confusion
❑ Trauma
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, overworking, dissatisfaction
❑ Worries
❑ Other: _____

_____

E. Health/Medical History

Primary Care Physician:_____Phone_____
Psychiatrist (if applicable):_____Phone_____

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please initial here _____

Current Medical Problems: Please list any current medical conditions, symptoms, or concerns:

_____
_____
_____

How would you rate your overall health? Excellent ___ Good ___ Fair ___ Poor ___

Client's name: _____ Case #: _____ Date: _____

Medical History: check all that apply Please explain if yes.

Hospitalizations	❑ No	❑ Yes:	_____
Surgery	❑ No	❑ Yes:	_____
Allergy	❑ No	❑ Yes:	_____
Seizure history	❑ No	❑ Yes:	_____
Major medical condition	❑ No	❑ Yes:	_____
Infectious disease	❑ No	❑ Yes:	_____
Sleep problems	❑ No	❑ Yes:	_____
Neurological condition	❑ No	❑ Yes:	_____
Chronic pain	❑ No	❑ Yes:	_____
Major medical condition	❑ No	❑ Yes:	_____
Substance abuse	❑ No	❑ Yes:	_____
Other:	❑ No	❑ Yes:	_____
Other:	❑ No	❑ Yes:	_____

Please list all medical and treatment providers:

Name	Specialty	Purpose	Goals or Outcome	Active? Y/N

Please list all medications:

Name of medication	dosage	purpose	prescriber

Health habits

What types of physical exercise do you get? How frequently?

_____

_____

How much of the following do you ingest or use daily?

Caffeine_____ Nicotine_____

Alcohol_____ Marijuana_____

Other_____

Do you have any problems getting enough sleep? ❑ No ❑ Yes: _____

_____

_____

Client's name: _____ Case #: _____ Date: _____

Are there any other medical or physical problems you are concerned about?

_____

_____

_____

F. Psychiatric/ Mental Health History

Please list all mental health diagnoses:

Diagnosis:	By whom	When

Mental Health History: do you have a history of any of the following?

Anxiety	❑ No	❑ Yes:	_____
Depression	❑ No	❑ Yes:	_____
Trauma	❑ No	❑ Yes:	_____
Bullied	❑ No	❑ Yes:	_____
Aggression	❑ No	❑ Yes:	_____
Video gaming addiction	❑ No	❑ Yes:	_____
Pathological gambling	❑ No	❑ Yes:	_____
Unusual thoughts	❑ No	❑ Yes:	_____
Self-harm behaviors	❑ No	❑ Yes:	_____
Suicidal thoughts or behavior	❑ No	❑ Yes:	_____
Homocidal thoughts or behavior	❑ No	❑ Yes:	_____
Inpatient mental health treatment	❑ No	❑ Yes:	_____
Outpatient mental health treatment	❑ No	❑ Yes:	_____
Sexualized behavior	❑ No	❑ Yes:	_____
Other	❑ No	❑ Yes:	_____

Please list any past psychiatric / psychological treatment you have had, including dates of treatment and names of treatment providers:

_____

_____

_____

Describe both the benefits and limits of the treatment:

_____

_____

Hospitalizations: Please list any times you have been hospitalized, included reasons and durations:

_____

_____

Suicidal thoughts, suicide attempts or violent behavior (describe your ages at the time of incidents, reasons, circumstances, methods, etc.):

_____

Do you have any past or current drug and alcohol problem? ❑ No ❑ Yes:_____

_____

G. Family Psychiatric and Developmental History

Diagnosis	Family Member	Myself	Comments
Drug or alcohol problems			
Depression			
Anxiety			
Attention deficit disorder			
Explosive behavior			
Learning disabilities			
Developmental delays			
Bipolar disorder			
Schizophrenia/Psychosis			
Personality disorder			
Other			

Choose the description(s) that best characterize your relationship growing up with your parent(s) or guardian(s) who raised you:
1) Physically abusive/abandonment
2) Verbally abusive and/or neglect
3) Distant/superficial
4) Supportive
5) Very loving and supportive with active involvement in your life

Please tell me about any major crises, stressors, and traumas experienced by you or immediate family members during your lifetime:_____

_____

Difficulties with social interaction_____

_____

Sleep problems, night terrors_____

H. Legal
Past Legal/ Litigation History (Describe past incarcerations, lawsuits and other criminal or civil litigations):

_____

Are you presently involved in any current or pending civil or criminal litigations, lawsuits, or divorce and custody disputes? ❑ No ❑ Yes: _____

_____

Are you or any family members under the supervision of the Department of Corrections? ❑ No ❑ Yes:

_____

Client's name: _____ Case #: _____ Date: _____

I.Education/Occupation

What is the highest level of education that you have completed?

❑ Grade school/Junior high
❑ High school or GED
❑ Undergraduate degree
❑ Graduate degree

Occupation: _____ Employed? ❑ No ❑ Yes (position/job title):_____

Is there anything else I should know that doesn't appear on this form, but might be important for me to know about?

_____

_____

----------Stop Here----------

Please bring your completed form to your first appointment

For therapist use:

Date Services Were Requested_____Date of First appointment _____

Assessment completed
by_____Date_____

(Attach Addendum I to complete Intake Assessment)

Client's name: _____ Case #: _____ Date: _____