### INTAKE FOR A STEADY SPACE, LLC

##### A. GENERAL INFORMATION

Client Name: Date of Birth:

Sex:  M  F Marital Status:

What is the presenting problem?

Have you had any experience with past counseling?  Yes  No. If yes, when was the last

time? And for how long?

Please list medical conditions and any medications you take.

Do you take steroids?  Yes  No Do you take Testosterone? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing financial problems?  Yes  No

Are you experiencing any legal problems?  Yes  No

Have you had troubles at work?  Yes  No If yes, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you have as your support system (friends and family)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### B. PSYCHOLOGICAL INFORMATION

1. How would you rate your level of energy?  Low  Regular  High
2. Do you experience any sleep disturbance?  Yes  No. If yes, please check all that apply: Difficulty falling asleep  Waking up too early and not being able to go back to sleep.  Sleeping too much- over 8-9 hours daily.  Not being able to sleep for more than 3 hours per night for a few nights consecutively.
3. Have you experienced any appetite changes in the past two weeks?  Yes  No. If yes, please check one that applies:  Increase in appetite  Decrease in appetite.
4. Do you find yourself getting easily irritated?  Yes  No
5. How would you rate your self esteem?  Low  Medium  High
6. Do you experience feelings of hopelessness?  Yes  No
7. Do you experience feelings of helplessness?  Yes  No
8. Do you have a history of psychiatric problems?  Yes  No If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Are you a danger to yourself now?  Yes  No. Have you ever attempted suicide?

Yes  No. Ever hospitalized?  Yes  No. If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. Do you have a history of violent behavior? Yes  No. If yes, please describe your recent violent behaviors. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there a family history of: Suicide: Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression:  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Violence:  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you go on uncontrollable shopping sprees?  Yes  No
2. Do you gamble?  Yes  No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you have obsessions or compulsions?  Yes  No If yes, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### **D. SUBSTANCE ABUSE SCREEN**

1. What types/frequency of drugs (including prescription) and alcohol have/do you use/d?
2. Do you think you are a “normal” drinker?  Yes  No
3. Have you ever had memory problems following drinking the night before?  Yes  No
4. Does any member of your family ever worry or complain about your drinking or drug use?  Yes  No
5. Are you able to stop drinking or using when you want?  Yes  No
6. Have you ever attended AA or other 12 step or drug/alcohol treatment programs?

Yes  No. If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has drinking or drug use ever created problems between you and your partner or other family members?  Yes  No
2. Have you ever missed work or other obligations because of drinking?  Yes  No
3. Is there a family history of alcohol or drug problems?  Yes  No