### 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