**FREMONT COUNSELING SERVICE**

**Client information Form – please respond to all questions.**

**Client's Last Name** **Client's First Name** **Middle Initial**

**Maiden Name / Other Names or Aliases** **Do you have a twin?** ☐ Yes ☐ No

**Mailing Address** (Address 1) **City** **State** **ZIP**

**Physical Address** (Contact Details: Address 2) **City** **State** **ZIP**

**Telephone Number** ☐ Home ☐ Work **Can we leave a message?** ☐Voice ☐Text

**Mobile Telephone Number** ☐ No mobile phone **Can we leave a message?** ☐Voice ☐Text

**Remind me of my appointments by:** ☐Email ☐Phone Call / Voice Mail ☐ Mobile Text ☐ Patient Portal

Text and Patient Portal require Patient Portal access.

**Email Address** (**Email address is required to access the Patient Portal.**)

**Social Security Number** (***Required to receive discounted services***) **Date of Birth**

**Mother's First Name** **Client's Place of Birth: City** **State** **Country**

**Gender**: ☐ Male ☐ Female ☐ Other _____

**Marital Status:** ☐ Never Married ☐ Now Married ☐ Divorced ☐ Widowed ☐ Minor Child

**Race:** ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Hispanic
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ More than One

**Hispanic Origin:** ☐ Not Hispanic ☐ Cuban ☐ Other Hispanic ☐ Mexican ☐ Puerto Rican

**Employment Status:** ☐ Employed - Less than 30 hrs/wk ☐ Employed - More than 30 hrs/wk
☐ Unemployed ☐ Unemployed - Disabled ☐ Homemaker ☐ Retired
☐ Child (0-15 yrs) ☐ Student (16+ yrs) ☐ Inmate ☐ Volunteer

**Residential Status:**
☐ Lack a fixed, regular residence (includes shelters, transitional housing, street, vehicle, staying with friends/relatives)
☐ Private Residence / Household ☐ Group Home ☐ Residential Treatment ☐ Foster Home
☐ Jail ☐ Other Residential Setting ☐ Unknown

**Primary Language:** ☐ English ☐ Spanish ☐ Sign Language ☐ Other: _____
Will you require translation services? ☐ Yes ☐ No

**Veteran Status:** ☐ Not a Veteran ☐ Non-Combat Veteran ☐ Combat Veteran

**Last Grade of School Completed:** _____ ☐ High School/GED ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

## FREMONT COUNSELING SERVICE

**Is the client currently on:** ☐ **Probation under Supervision** ☐ **Probation not under Supervision** ☐ **Parole**

**TOTAL ANNUAL HOUSEHOLD INCOME: $**_____ **Total People in Household:** _____

**Primary Income Source:**

| | | |
|---|---|---|
| ☐ Self | ☐ Family (Parent/Guardian/Spouse/Adult Children | ☐ Retirement |
| ☐ DFS / Welfare | ☐ SSI (Supplemental Security Income) | ☐ Unemployment |
| ☐ Other Disability | ☐ SSDI (Social Security Disability Income) | ☐ Other |

**PERSON RESPONSIBLE FOR PAYMENT OF SERVICES**

Responsible Person's Name | Social Security Number | Date of Birth

Address | City / State / ZIP | Phone Number | Relationship to Client

Insurance Company | Policy/Group ID Number | Copay Amount

**Please present your insurance card to the front desk at check in.** ☐ No Insurance

**LEGAL STATUS** ☐ Adult, no Guardian ☐ Adult, has Guardian ☐ Minor, has Guardian ☐ Minor, Emancipated

**Guardian's Name** **Address / City / State / ZIP** **Phone Number**

**Relationship:**
☐ Spouse / Domestic Partner ☐ Sibling ☐ Parent / Foster Parent / Grandparent ☐ Child ☐ Friend ☐ Guardian / Legal Representative

**EMERGENCY CONTACT**

**Name** **Address / City / State / ZIP** **Phone Number**

**Relationship:**
☐ Spouse / Domestic Partner ☐ Sibling ☐ Parent / Foster Parent / Grandparent ☐ Child ☐ Friend ☐ Guardian / Legal Representative

**Who referred you to us?**

| | | | |
|---|---|---|---|
| ☐ Self | ☐ Family / Friends | ☐ Law Enforcement | ☐ School |
| ☐ Attorney | ☐ Other MD | ☐ Other Private MH Provider | ☐ Wyoming State Hospital |
| ☐ DVR | ☐ Employer | ☐ Drug / Alcohol Treatment | ☐ Drug Court |
| ☐ DFS | ☐ CDS / Head Start | ☐ Juvenile Probation – DFS | ☐ Medical Hospital |
| ☐ Nursing Home | ☐ Shelter | ☐ Veterans Affairs | ☐ Adult Probation/Parole |
| ☐ Other | ☐ Clergy | ☐ Other MH Center | ☐ Court |
| ☐ Private Psychiatrist | ☐ CES / WLRC | ☐ Dept. of Corrections | ☐ Other Inpatient Treatment |

**If self-referred, how did you hear about us?**

☐ Internet Search ☐ Newspaper ☐ Radio ☐ TV ☐ Other: _____

Signature of Person Completing Form | Date

Name of Person Completing Form | Phone Number

**FREMONT COUNSELING SERVICE**
**Intake Form**

Name: _____ Age: _____ Date: _____

***All responses to these questions are kept strictly confidential and are included in your clinical record.***

**PRESENTING PROBLEMS AND CONCERNS**

Please describe the problem that brought you here today: _____

_____

_____

Please check all of the behaviors and symptoms that you consider to be problematic for you:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death/suicide
- ☐ Self-harming behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other: _____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/school
- ☐ Recreational Activities
- ☐ Self-esteem
- ☐ Housing
- ☐ Health
- ☐ Relationships
- ☐ Legal matters
- ☐ Sexual Activities
- ☐ Hygiene
- ☐ Finances

Please note if you have experienced or witnessed any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Terrorism
- ☐ Sexual abuse/assault
- ☐ Physical abuse/assault
- ☐ Parent substance abuse
- ☐ Teen/unplanned pregnancy
- ☐ Neglect
- ☐ Combat Veteran
- ☐ Violence in the home
- ☐ Crime victim
- ☐ Significant parent illness
- ☐ Place a child for adoption
- ☐ Lived in a foster home
- ☐ Natural disaster
- ☐ Multiple family moves
- ☐ Homelessness
- ☐ Loss of a loved one
- ☐ Financial problems

☐ Other: _____

## PREVIOUS MENTAL HEALTH TREATMENT

Have you had any previous mental health or substance use treatment?

| YES | When? | Where? | Reason for Treatment? |
|---|---|---|---|
| ☐ Outpatient counseling | | | |
| ☐ Medication | | | |
| ☐ Psychiatric hospitalization | | | |
| ☐ Drug/alcohol treatment | | | |
| ☐ Self-help/support groups | | | |

## SUBSTANCE USE HISTORY

| Do you use or have you used: | | How often? | How much? | Age of first use? |
|---|---|---|---|---|
| ☐ Tobacco | ☐ Current ☐ Past | | | |
| ☐ Caffeine | ☐ Current ☐ Past | | | |
| ☐ Alcohol | ☐ Current ☐ Past | | | |
| ☐ Marijuana | ☐ Current ☐ Past | | | |
| ☐ Cocaine/crack | ☐ Current ☐ Past | | | |
| ☐ Ecstasy | ☐ Current ☐ Past | | | |
| ☐ Heroin | ☐ Current ☐ Past | | | |
| ☐ Inhalants | ☐ Current ☐ Past | | | |
| ☐ Meth | ☐ Current ☐ Past | | | |
| ☐ Rx Pain Killers | ☐ Current ☐ Past | | | |
| ☐ PCP/LSD | ☐ Current ☐ Past | | | |
| ☐ Steroids / Tranquilizers | ☐ Current ☐ Past | | | |
| ☐ OTHER: | | | | |
| ☐ OTHER: | | | | |

Have you used any in the last 30 days? ☐ Cigarettes/cigar/pipe ☐ E-cig/vape pen ☐ Snuff/chew ☐ None

Have you attended AA/NA (or other social support group) in the last 30 days? ☐ Yes ☐ No

Have you ever had withdrawal symptoms when trying to stop taking any substances? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever had problems with work, relationships, the law, etc. due to substance use? ☐ Yes ☐ No

If yes, please describe: _____

## FAMILY AND DEVELOPMENTAL HISTORY

| | Maternal (Mother's Side) | WHO? | Paternal (Father's Side) |
|---|---|---|---|
| Family Mental Health Problems | ☐ | | ☐ |
| Sexually Abused | ☐ | | ☐ |
| Depression | ☐ | | ☐ |
| Suicide | ☐ | | ☐ |
| Anxiety/Panic Attacks | ☐ | | ☐ |
| Anger/Abusive | ☐ | | ☐ |
| Alcohol/Drug Abuse | ☐ | | ☐ |
| OTHER: | ☐ | | ☐ |
| OTHER: | ☐ | | ☐ |
| OTHER: | ☐ | | ☐ |
| OTHER: | ☐ | | ☐ |

Are your parents: ☐Legally married or living together? ☐Temporarily separated? ☐Divorced or permanently separated?

Mother remarried: _____ number of times

Father remarried: _____ number of times

What is the quality of your relationship with your:

| | | | | |
|---|---|---|---|---|
| Mother | ☐Good | ☐Poor | ☐No Relationship | ☐Other:_____ |
| Father | ☐Good | ☐Poor | ☐No Relationship | ☐Other:_____ |
| Step-Mother | ☐Good | ☐Poor | ☐No Relationship | ☐Other:_____ |
| Step-Father | ☐Good | ☐Poor | ☐No Relationship | ☐Other:_____ |
| Brothers/Sisters | ☐Good | ☐Poor | ☐No Relationship | ☐Other:_____ |
| Spouse/Partner | ☐Good | ☐Poor | ☐No Relationship | ☐Other:_____ |
| Children | ☐Good | ☐Poor | ☐No Relationship | ☐Other:_____ |

## INTERPERSONAL / SOCIAL / CULTURAL INFORMATION

Who would you include in your social support network?

☐Family ☐Neighbors ☐Friends ☐Students
☐Co-workers ☐Community group ☐Support/Self-help group
☐Religious/spiritual center (which one)? _____

How important are spiritual matters to you? ☐Very ☐Somewhat ☐Not at all

Do you live by yourself or with others? With who? _____

How long have you been in your current living situation? _____

Do you identify with a particular ethnic or cultural group? Which one(s)? _____

Are ethnic or cultural issues causing difficulty in your life? Please describe: _____

_____

What gender do you identify with: ☐Male ☐Female ☐Neither ☐Other: _____

What is your sexual orientation: ☐Straight ☐Gay/Lesbian ☐Bi-sexual ☐Other: _____

## LEGAL INFORMATION

Have you been arrested in the last 30 days? ☐Yes ☐No

Have you ever been convicted of a misdemeanor or felony? ☐Yes ☐No

If yes, please describe: _____

Are you currently involved in any divorce and/or child custody proceedings? ☐Yes ☐No

If yes, please describe: _____

## MEDICAL INFORMATION

_____

Date of last exam/treatment by a physician — Reason for last exam/treatment

_____

Physician (Name / Phone Number) — Psychiatrist (Name / Phone Number)

_____

Pharmacy / Location

Drug Allergies: _____

Do you have any psychiatric Advance Directives? ☐Yes ☐No (If yes, was a copy provided?)

Would you like more information on psychiatric Advance Directives? ☐Yes ☐No

## MEDICATION INFORMATION

Please include prescription medications as well as over-the-counter (OTC) medications, herbal supplements, vitamins, etc. If you need more space for more medications, please let reception know.

| Medication Name | How much and How often? | Do they help? Any side effects/bad reactions? | Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

_____

Signature of Person Completing Form — Date

_____

Name of Person Completing Form — Phone Number

**FREMONT COUNSELING SERVICE**
**Child/Youth Intake – Additional Questions**

Child's Name _____ Age _____

***All responses to these questions are kept strictly confidential.***

Has the child attended school in the last three (3) months:
☐ Yes
☐ No – not attending school ☐ No – on summer Break ☐ No – attends daycare/preschool
☐ Unknown

Has the child been suspended from school in the last three (3) months:
☐ Yes - suspended ☐ No – not suspended ☐ Unknown

**CUSTODIAL STATUS**
Who has legal custody of the child? _____

Who has parental rights of the child?
Mother ☐ Yes ☐ No
Father ☐ Yes ☐ No

Who has physical custody of the child? _____

**DEVELOPMENTAL HISTORY**
Were there complications with this pregnancy? ☐ Yes ☐ No ☐ Unknown
Did the mother sustain any major illness/injury while pregnant? ☐ Yes ☐ No ☐ Unknown

During the pregnancy, did the mother use:

| | | | |
|---|---|---|---|
| Tobacco? | ☐ Yes | ☐ No | ☐ Unknown |
| Alcohol? | ☐ Yes | ☐ No | ☐ Unknown |
| Prescription drugs? | ☐ Yes | ☐ No | ☐ Unknown |
| Other substances? | ☐ Yes | ☐ No | ☐ Unknown |

Was delivery: ☐ Early ☐ Normal ☐ Late ☐ Unknown
Were there any complications with/labor delivery? ☐ Yes ☐ No ☐ Unknown

When the child was an infant were they:

| | | | |
|---|---|---|---|
| Easy to comfort? | ☐ Yes | ☐ No | ☐ Unknown |
| Quiet? | ☐ Yes | ☐ No | ☐ Unknown |
| Excessively irritable? | ☐ Yes | ☐ No | ☐ Unknown |
| Prone to temper tantrums? | ☐ Yes | ☐ No | ☐ Unknown |
| Quick to anger? | ☐ Yes | ☐ No | ☐ Unknown |
| An excessive climber? | ☐ Yes | ☐ No | ☐ Unknown |
| Resistant to physical contact? | ☐ Yes | ☐ No | ☐ Unknown |
| Sleep too much / too little? | ☐ Yes | ☐ No | ☐ Unknown |
| Eat too much / too little? | ☐ Yes | ☐ No | ☐ Unknown |
| Eat things that were not food? | ☐ Yes | ☐ No | ☐ Unknown |

Developmental Milestones:

| | | | | |
|---|---|---|---|---|
| Gross motor? | ☐ Early | ☐ Average | ☐ Delayed | ☐ Unknown |
| Fine motor? | ☐ Early | ☐ Average | ☐ Delayed | ☐ Unknown |
| Social skills? | ☐ Early | ☐ Average | ☐ Delayed | ☐ Unknown |

Speech functioning? ☐ Normal ☐ Some Problems ☐ Requires Assistance ☐ Should be Evaluated
Hearing functioning? ☐ Normal ☐ Some Problems ☐ Requires Assistance ☐ Should be Evaluated
Visual functioning? ☐ Normal ☐ Some Problems ☐ Requires Assistance ☐ Should be Evaluated

Are the child's immunizations up to date? ☐ Yes ☐ No ☐ Unknown

Is the child able to form and maintain relationships? ☐ Yes ☐ No ☐ Unknown

Is the child's housing situation stable? ☐ Yes ☐ No ☐ Unknown

Is the child at risk for an out-of-home placement? ☐ Yes ☐ No ☐ Unknown

Current school, grade, and teacher name (if known), OR current day/childcare situation:

Does the child have an IEP or MDT in place? ☐ Yes ☐ No ☐ Unknown
Does the child have behavior problems at school / daycare? ☐ Yes ☐ No ☐ Unknown
Has the child had any educational evaluations? ☐ Yes ☐ No ☐ Unknown
How does the child's intellectual functioning appear? ☐ Below Average ☐ Average ☐ Above Average

**PARENT/GUARDIAN INVOLVEMENT**

Are you (as the child's parent/guardian) able and willing to participate in the child's services as indicated?
☐ Yes ☐ No

Please describe any special areas of interest, hobbies of the parent/guardian, or other things that the parent/guardian enjoys:

Do you have any needs or preferences for the treatment/services that your child receives? (For example: male or female clinician? How often would you like your child to be seen? Day/afternoon/evening appointments?)

What is your goal for treatment of your child? What do you hope to accomplish by your child receiving services from us?

Signature of Person Completing Form Date

Name of Person Completing Form Phone

**Patient Health Questionnaire (PHQ-9)**

Over the last two weeks, how often have you been bothered by any of the following problems?

| | Not at All | Several Days | More than Half the days | Nearly Every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 2. Feeling down, depressed, or hopeless | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. Trouble falling or staying asleep or sleeping too much | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 4. Feeling tired or having little energy | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 5. Poor appetite or overeating | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 7. Trouble concentrating on things-such as reading the newspaper or watching TV | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| Add Columns | | _____ + | _____ + | _____ |
| TOTAL: | | | | |

10. If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely Difficult

In the PAST YEAR, have you felt depressed or sad most days, even if you felt OK sometimes? ☐ Yes ☐ No

Has there been a time in the PAST MONTH when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you EVER, IN YOUR WHOLE LIFE, tried to kill yourself or make a suicide attempt? ☐ Yes ☐ No

## Generalized Anxiety Disorder (GAD-7)

Over the last two weeks, how often have you been bothered by any of the following problems?

| | Not at All | Several Days | More than Half the days | Nearly Every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 2. Not being able to stop or control worrying | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. Worrying too much about different things | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 4. Trouble relaxing | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 5. Being so restless that it's hard to sit still | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 6. Becoming easily annoyed or irritable | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| 7. Feeling afraid as if something awful might happen | ☐ | ☐ 1 | ☐ 2 | ☐ 3 |
| Add Columns | | _____ | + _____ | + _____ |
| TOTAL: | | | | |

8. If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely Difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.