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

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.