INTAKE CHECKLIST

NAME: _____ Date of Birth _____

To serve you better, please circle your answer to each question below.

1) Do you have any current or history of medical conditions/illnesses? Yes No
If yes, explain _____

Are you on any current medications/treatment? Yes No
If yes, medication/treatment _____
Physician name/phone _____

3) Are you having difficulty sleeping? Yes No

4) Have you/others been concerned about your alcohol or drug use? Yes No

5) Do any family members have alcohol or drug problems? Yes No

6) Do you have any eating disorders/concerns? Yes No

7) Do you have thoughts about hurting yourself? Yes No

8) Do you have any thoughts about hurting others? Yes No

9) Do you feel you are in danger of being hurt? Yes No

10) Have you moved in the last two years? Yes No

11) Do you find it hard to talk about personal problems with other people? Yes No

12) Do you have problems in your relationships with other people? Yes No

13) Do you prefer not to participate in social activities? Yes No

14) Have you changed jobs/schools in the last two years? Yes No

15) Do you hate going to work/school? Yes No

16) Do you have a legal problem? Yes No

17) Are your experiencing financial problems? Yes No

18) Have you lost hope that your problem can be resolved? Yes No

19) Are you interested in spiritual growth? Yes No

20) Are you seeking meaning and purpose to your life? Yes No