Turning Leaf Therapy

ADULT INTAKE QUESTIONNAIRE

CURRENT LIFE SITUATION

What brings you to therapy at this time?

Please indicate any symptoms you have experienced in the past 6 months:

- ☐ Depressed Mood
- ☐ Helplessness
- ☐ Decreased Energy
- ☐ Feelings of Worthlessness
- ☐ Hopelessness
- ☐ Social Withdrawal
- ☐ Irritability
- ☐ Loss of Interest
- ☐ Feeling tense or on-edge
- ☐ Excessive anxiety/worry
- ☐ Distractibility
- ☐ Difficulty concentrating
- ☐ Obsessions
- ☐ Compulsions
- ☐ Phobias
- ☐ Inflated self-esteem
- ☐ Grandiosity
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Shame
- ☐ Grief
- ☐ Sleep disturbance
- ☐ Stomach aches
- ☐ Headaches
- ☐ Racing heart-beat
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Hyperactivity
- ☐ Delusions
- ☐ Paranoia
- ☐ Dissociative states
- ☐ Panic attacks
- ☐ Fear of leaving your home
- ☐ Auditory hallucinations
- ☐ Visual Hallucinations
- ☐ Olfactory Hallucinations
- ☐ Suicidal Ideations
- ☐ Homicidal Ideations
- ☐ Self-injurious behaviors
- ☐ High-risk sexual behaviors
- ☐ Promiscuity
- ☐ Sexual compulsions
- ☐ Property destruction
- ☐ Fire setting
- ☐ Cruelty to animals
- ☐ Stealing
- ☐ Deception
- ☐ Substance abuse
- ☐ Restlessness
- ☐ Ruminating thoughts
- ☐ Fear of social interactions
- ☐ Excessive use of pornography

Relationship Status:

- ☐ Married
- ☐ Divorced
- ☐ Single
- ☐ Domestic Partnership
- ☐ Long-term relationship
- ☐ Widowed
- ☐ Other

Employment Status:

- ☐ Part-time
- ☐ Full-time
- ☐ Part-time student
- ☐ Full-time student
- ☐ Unemployed
- ☐ Retired
- ☐ Other

Current Living Arrangement:

- ☐ Living Alone
- ☐ With Roommates
- ☐ With Family
- ☐ With Partner
- ☐ Assisted Living
- ☐ Homeless
- ☐ Halfway House
- ☐ Other

What areas are currently affected by your presenting concern?

- ☐ Mental Health Services
- ☐ Dental Health
- ☐ Educational Functioning
- ☐ Use of Drugs or Alcohol
- ☐ Vocational Functioning
- ☐ Self-Care/ILS
- ☐ Social Functioning
- ☐ Interpersonal Functioning
- ☐ Use of Transportation
- ☐ Medical Health
- ☐ Obtaining/ Maintaining Housing
- ☐ Obtaining/ Maintaining Employment

Current Life Stressors:

What are some of your strengths?

What are some of your vulnerabilities?

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SUBSTANCE USE

Have you ever felt bad or guilty about your drinking or drug use?

Have people annoyed you by criticizing your drinking or drug use?

Have you ever felt that you ought to cut down on your drinking or drug use?

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

HISTORY

Have you sought out any mental health care previously? If so, please explain

Have you ever been hospitalized for a psychiatric issue?

Any significant medical history, current medical conditions, or current medications or supplements you are taking?

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

2589 Hamline Ave. N., Unit C, Roseville, MN 55113
P: 651-330-6205 F: 651-330-8718
www.turningleaftherapy.org

If you are in a relationship, please describe the nature of the relationship and months or years together.

If you have children, please list their names, ages, and if they are living with you or not.

Is there a history of mental illness in your family?

Any cultural considerations and/or belief systems that influence you?

What are your goals for therapy?

What else would you like me to know?

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