Client Name:

Client CATT #:

INTAKE QUESTIONNAIRE

Please answer these questions in order for us to best help you/your child.

Name: _____ **Date:** ____/____/____ **CATT #:** _____

What brought you (your child) here today? _____

_____

_____

What is your (your child)'s most important goal to accomplish with us? _____

_____

_____

Please rate how confident you (your child) are in your ability to accomplish this goal.

❑ ……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑

Not at all confident *Somewhat Confident* *Very Confident*

Please rate how ready you (your child) are to take the next steps towards this goal.

❑ ……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑……..……..❑

Not Ready *Somewhat Ready* *Very Ready*

EXPERIENCES

Please mark if you (your child) has experienced any of the below:

- ☐ Feelings of ***sadness or depression***
- ☐ Thoughts of/attempts to ***hurt yourself***
- ☐ A ***loss*** in your life
- ☐ Feelings of ***worry or anxiety***
- ☐ Experienced a ***traumatic event***
- ☐ Feelings of ***anger*** or have thoughts of hurting someone
- ☐ ***Difficulties with people in authority*** at home, school, or work
- ☐ ***Difficulty concentrating*** or paying attention
- ☐ ***Seeing or hearing things*** that others don't see or hear
- ☐ ***Mood swings*** or times when you have ***too much energy***
- ☐ Misuse of ***drugs or alcohol***
- ☐ ***Acting without thinking*** about consequences
- ☐ Changes to ***appetite or food intake***
- ☐ Difficulty ***falling asleep or staying asleep***
- ☐ Any behaviors you ***wish you could stop but can't***
- ☐ Problems with ***pain in your body that you can't manage***
- ☐ Additional ***stressors***: _____

_____

_____

ARE YOU (YOUR CHILD) FACING ANY OF THESE DIFFICULTIES WITH COMING TO SOUTH COMMUNITY?

- ☐ Unreliable transportation
- ☐ Unable to drive
- ☐ Legal difficulties
- ☐ Family disapproves
- ☐ Fearful about therapy
- ☐ Child care
- ☐ Scheduling conflicts
- ☐ Finances/co-payment
- ☐ Illness in family
- ☐ Travel too far
- ☐ Health concerns
- ☐ Other _____

Client Name:

Client CATT #:

MENTAL HEALTH/SUBSTANCE

PAST TREATMENT

Have you (your child) ever been treated for a mental health condition by any of the following providers?

	Year	Case Mgmt/ Therapy	Meds	Hospital		Year	Case Mgmt/ Therapy	Meds	Hosp ital
☐ ATS/Wellness	_____	☐	☐	☐	☐ Kettering Hospital	_____	☐	☐	☐
☐ CAM	_____	☐	☐	☐	☐ Miami Valley	_____	☐	☐	☐
☐ DayMont	_____	☐	☐	☐	☐ South Community	_____	☐	☐	☐
☐ Eastway	_____	☐	☐	☐	☐ Summit	_____	☐	☐	☐
☐ Good Samaritan	_____	☐	☐	☐	☐ Twin Valley	_____	☐	☐	☐
☐ Grandview	_____	☐	☐	☐	☐ KBMC	_____	☐	☐	☐
☐ Sam Behavioral	_____	☐	☐	☐	☐ Other	_____	☐	☐	☐

Previous or **Current** Mental Health Diagnosis (if known)? _____

_____

SUBSTANCE HISTORY (Check one box for EACH SUBSTANCE as appropriate)

Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use
Alcohol/Beer/Wine				Hallucinogens			
Marijuana				Inhalants			
Hashish				Cocaine/Crack			
Stimulants				Heroin			
Sleep Medication				Pain Medication			
Tranquilizers				Other:			

Have you (your child) ever received substance abuse treatment? qNo qYes	**If yes, where?**
Caffeine use? If yes, form (coffee, tea, pop, etc.) qNo qYes	**How much per week** (cups, bottles)?
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) qNo qYes	**How much per week (packs, etc.)?**

ARE YOU LOOKING FOR A NEW FAMILY PHYSICIAN?

☐ **Yes**	☐ **Not Sure**	☐ **Not At This Time**

Client Name:

Client CATT #:

A Little About You/Your child!

Please let us know a little about the person to receive services.

For each item, indicate whether that area of your (your child's) life is a source of ***problems/concern***, a source of ***strength***, or ***neither***.

Living Situation	___ Area of CONCERN	___ Source of STRENGTH	___ Neither
This includes how you (your child) feel about your home or where you (they) live.			

Family	___ Area of CONCERN	___ Source of STRENGTH	___ Neither
This includes how well you (your child) get along with others in the family and with those you live.			
Marital Status: __ Single __Married __Divorced __ Other **Do you find members of your (your child's) family to be supportive**?: __ Yes __ No __ Sometimes __ Unsure			
Is there a history in your (your child's) family of (check all that apply): __ Mental Health Issues __Substance Abuse __Trauma __ Legal Issues			
Who in your (child's) home/family is <u>most supportive</u>? _____ **With whom do you (child) have <u>the most problems</u>? _____ _____**			

Social	___ Area of CONCERN	___ Source of STRENGTH	___ Neither
This includes how you (your child) get along and what you do with other people who are NOT related to you or live with you.			
I feel good about the number of and relationships I (my child) have with friends: ___ Yes ___ No			
I am (my child is) involved in the following meaningful activities (check all that apply): ___ volunteer activities ___ recreational activities ___ community involvement ___ Other: _____			
I am (my child is) involved in the following support Groups (check all that apply): ___ NAMI ___ AA/NA ___ Other: _____			

Activities of Daily Living	___ Area of CONCERN	___ Source of STRENGTH	___ Neither
This includes how well you believe you (your child) are able to take care of basic tasks of everyday life, such as eating, bathing, dressing, making appointments, managing your money.			

Religion/Spirituality	___ Area of CONCERN	___ Source of STRENGTH	___ Neither
This may include your (your child's) beliefs and actions or others' reactions to your beliefs and actions.			

Culture/Ethnicity	___ Area of CONCERN	___ Source of STRENGTH	___ Neither
This may include your (your child's) beliefs, customs, attitudes or race that you feel distinguishes you.			

Client Name:

Client CATT #:

SEXUAL HISTORY ___ Area of CONCERN ___ Source of STRENGTH ___ NEITHER

This may include your(your child's) feelings toward sex or sexuality.

EDUCATION ___ Area of CONCERN ___ Source of STRENGTH ___ NEITHER

This includes any information related to school: learning, relationships with peers/teachers, attendance, behavior.

Are you (your child) currently attending school? ☐ Yes ☐ No

If yes, where? _____

History of Learning/Developmental Challenges:

___ NONE ___ Learning Disability ___ Developmental Delays ___ Special School Placement ___ Other**:** _____

LEGAL ___ Area of CONCERN ___ Source of STRENGTH ___ NEITHER

This includes any information related to your (your child's) past or current legal involvement.

Current Legal Status:

___ None Reported ___ On Probation ___ Detention ___ On Parole ___ Awaiting Charge ___ Outpatient Commitment ___ Other

Past Legal Status:

___ None Reported ___ On Probation ___ Detention ___ On Parole ___ Awaiting Charge ___ Outpatient Commitment ___ Other

LETHALITY ___ Area of CONCERN ___ Source of STRENGTH ___ NEITHER

This includes any information related to your (your child's) past or current harm to self or others.

Present: ___ None Reported ___ Thoughts to harm self ___ Thoughts to harm others ___ Attempts to harm self ___ Attempts to harm others

Past: ___ None Reported ___ Thoughts to harm self ___ Thoughts to harm others ___ Attempts to harm self ___ Attempts to harm others

EMPLOYMENT HISTORY ___ Area of CONCERN ___ Source of STRENGTH ___ NEITHER

This includes any information related to your (your child's) employment, including ability to learn and complete tasks, relationships with others, attendance, and corrections

I am (my child is) currently:

___ Not employed ___ Employed Full Time ___ Employed Part Time ___ Volunteer Work

If you (your child) are not employed, are you (your child):

___ Disabled ___ Retired ___ Homemaker ___ Student ___ Other: _____

Job Performance: **Attendance** ___ No Problems ___ Frequent Tardiness ___ Frequent Absences ___ Not Applicable

Performance ___ Exemplary ___ Good ___ Average ___ Below Average

ABUSE HISTORY ___ Area of CONCERN ___ Source of STRENGTH ___ NEITHER

This includes any information related to past or current abuse where you (your child) were the victim or perpetrator.

___ None Reported ___ Physical ___ Sexual ___ Emotional ___ Neglect ___ Domestic Violence ___ Community Violence ___Other