CENTRAL FOCUS
PSYCHOLOGICAL GROUP

1259 Lake Plaza Dr, Suite 255
Colorado Springs, CO 80906

P: (719) 598-3585/F: (720) 358-2674
www.centralfocusgroup.com

Intake Form

**** Please fill this form out for the client who is engaging in services. This could be yourself or anyone for whom you have legal guardianship (e.g., minor, child, etc.).****

CLIENT INFORMATION		
Full Name: Name that you like to be called (nickname):		Relationship Status: □ S □ M □ D □ Sep □ W □ Partner
Date of Birth:	Age:	Sex: □ M □ F
Occupation:	Social Security #:	
Home Phone #: Ok to leave voicemail? □ Yes □ No	Cell Phone#: Ok to leave voicemail? □ Yes □ No	
Home Address: State: Zip: Ok to mail to this address? □ Yes □ No		
Employer/Company Name: Work Phone #:	Email: Ok to email? □ Yes □ No (Please note that email correspondence is not guaranteed to be confidential)	
Emergency Contact Name: Relationship to Patient:	Emergency Contact Phone #: Next of Kin:	

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Have you previously attended mental health services? □ Yes □ No What kind of services? Inpatient /Outpatient/Other:	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending services?

BIOPSYCHOSOCIAL HISTORY			
Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Depressed Mood	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Appetite Disturbances	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Sleep Disturbances	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Change in Energy Level	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Decreased Concentration	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Worthless/Helpless Feelings	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Anxiety Symptoms/ Panic Attacks	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Bingeing/Purging	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Feelings of Guilt	□Yes	□ No	If "Yes", circle severity: Low 1 2 3 4 5 6 7 8 9 10 High
Obsessions/ Compulsions	□Yes	□ No	If "Yes", please describe:
Phobias	□Yes	□ No	If "Yes", please describe:
Medical Conditions	□Yes	□ No	If "Yes", please describe:
Hyperactivity	□Yes	□ No	If "Yes", please describe:

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Are you having suicidal thoughts?	□Yes	□ No	If "Yes", do you have a plan about how you would commit suicide:
Do you have the means to carry out your plan?	□Yes	□ No	If "Yes", how would you do this?
Have you ever made a suicide attempt or been hospitalized for suicide?	□Yes	□ No	Describe: Date(s) of attempt(s):
Is there a history of suicide in your family of origin?	□Yes	□ No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a clinician or psychiatrist?	□Yes	□ No	If yes, please list the diagnosis's and the years:

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)

1.
2.
3.
Prescriber:

List anything other medications or comments that your clinician should be aware of regarding your physical or mental health:

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No
Have you ever been arrested for a DUI, or drug use? Or do you have a past that involves using drugs or alcohol. Please briefly describe circumstances below:	□Yes	□ No

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Family & Relationship History (Use reverse side of this page if you need additional space)

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Spouse/Partner	_____	_____	_____	_____
Parent	_____	_____	_____	_____

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Parent	_____	_____	_____	_____
Stepparent	_____	_____	_____	_____
Stepparent	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children/Step	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Are your parents divorced? □ Yes □ No Remarried? □ Yes □ No

Religion (if any) _____

Sexual orientation _____

Gender orientation_____ (female, male, transgender, transsexual)

Ethnic Group (select all that apply):

American Indian	Alaskan Native	Caucasian	Middle Eastern
Asian	Phillipino	Native Hawaiian	Pacific Islander
Hispanic/Latino	Black/African American	Multi-Ethnic/Other_____	

Family of Origin (Circle Your Answer)

Have you experienced any abuse in your family or relationships?

None Emotional Physical Sexual Uncertain

In general, how happy were you growing up?

None Somewhat Mostly Extremely

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How much is your family of origin a source of support for you?

None Somewhat Very Extremely

How much conflict in values do you experience with your parents?

None Somewhat Substantial

Legal Issues

Have you personally experienced legal problems? □ No □ Yes (describe)

Are you currently involved in a lawsuit? If so please describe:

Briefly describe concerns in your life and/or in your relationships that would be relevant for your clinician to know. You may use the back of the form for more space if needed:

On a scale of one to ten, how motivated are you to resolve this issue? _____

Please list your therapy goals (list as many that apply & use the back if need be):

1.

2.

3.

Thank you for taking the time to read and complete these questions.