MURRAY, WILSON & ROSE
COUNSELING AND BEHAVIORAL SERVICES

# CONFIDENTIAL CLIENT INTAKE SUMMARY

Legal Name: _____ Preferred Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ SSN: _____ Sex Assigned at Birth: ___

**Marital Status:**
▢ Single
▢ Married
▢ Divorced
▢ Widowed
▢ Partnered

**Student Status:**
▢ Not a student
▢ Full time
▢ Part time
Name of school: _____

**Employment Status:**
▢ Full time
▢ Part time
▢ Self employed
▢ Not employed
▢ Retired
▢ Active Duty Military
▢ Other: _____
Employed by: _____
Occupation: _____

**Referred By:**
▢ Community Event: _____
▢ Current/Former MWR Client
▢ EAP Provider: _____
▢ Family/Friend/Colleague
▢ Google/Online Search
▢ Insurance Provider: _____
▢ Medical or Healthcare Provider: _____
▢ Psychology Today
▢ School
▢ Social Media
▢ Other: _____

Phone Number: ____ - ____ - _____ May we leave messages at this number? Yes ▢ No ▢

Email Address: _____ May we leave messages at this address? Yes ▢ No ▢

May we send e-statements to review your account online? Yes ▢ No ▢

Would you like email appointment reminders? Yes ▢ No ▢

Would you like text appointment reminders? Yes ▢ No ▢

Who is your emergency contact? _____

Relationship: _____ Phone number: _____

What is your preferred pharmacy? Please include name and street address. _____

_____

## GOALS OF MEDICATION MANAGEMENT

Brief description of why you're seeking medication management at this time: _____

_____

_____

What would you like to achieve through medication management? _____

_____

_____

Who or what are your current sources of support? _____

_____

_____

## PSYCHIATRIC HISTORY

Please list all current psychiatric medications, including dosage, frequency, how long you have been taking this medication, and who prescribes this medication: _____

_____

_____

_____

_____

Please list all other medications, vitamins, supplements, or essential oils. Include dosage, frequency, how long you have been taking this medication, and who prescribes it: _____

_____

_____

_____

_____

Please indicate whether you have taken any of the following medications in the past. Indicate the dates, dosage, frequency, whether they were helpful to you, and any side effects that you remember experiencing.

*Antidepressants:*
Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortriptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other _____

*Mood Stabilizers:*
Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Tegretol (carbamazepine) _____
Topamax (topiramate) _____
Other _____

*Antipsychotics/Mood Stabilizers:*
Seroquel (quetiapine) _____
Zyprexa (olanzapine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____

Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____

*Sedatives/Hypnotics:*
Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

*ADHD Medications:*
Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

*Antianxiety Medications:*
Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____

Please list any allergies: _____

_____

_____

Please list any relevant medical conditions: _____

_____

_____

Please list any relevant major illnesses, injuries, diagnoses, or surgeries: _____

_____

_____

Describe any relevant current health problems or concerns: _____

_____

_____

How would you rate your overall health? Excellent ▢ Good ▢ Fair ▢ Poor ▢

Do you exercise regularly? Yes ▢ No ▢ If yes, what types of exercise? _____

Current family practice provider: _____

Current psychiatric provider: _____

Please list any other specialists you see, including neurologists, pain management specialists, or gynecologists: _____

_____

Have you had previous outpatient counseling? Yes ▢ No ▢

Please list your previous counseling or psychiatric providers, including treatment dates, response to treatment, and response to medication: _____

_____

_____

Have you had any previous mental health or medical hospitalizations? Yes ▢ No ▢ If yes, please briefly describe: _____

_____

_____

Are there any other services that you are currently involved with for your mental health or medical care? Please list. _____

_____

***Please note that you will need to fill out releases of information for your family practice provider, your psychiatric provider, and any relevant specialists for coordination of care.***

## REPRODUCTIVE AND GYNECOLOGICAL HISTORY

Have you ever been prescribed birth control or taken exogenous hormones? Yes ▢ No ▢

Are you currently still prescribed birth control or exogenous hormones? Yes ▢ No ▢

Please list which birth control and/or exogenous hormones you have taken in the past, or are currently taking: _____

_____

Please describe any side effects you experienced from your birth control and/or exogenous hormones:

_____

_____

## MATERNAL MENTAL HEALTH AND MEDICAL HISTORY

Number of pregnancies: _____ Abortion/termination: _____ Miscarriage: _____ Live birth: _____

Complications during pregnancy/delivery/postpartum: _____

_____

_____

How would you describe your birth(s)? Did you experience anything you consider traumatic? _____

_____

_____

How did you feed/how are you currently feeding your baby? _____

Do you have any previous history of depression/anxiety? Yes ▢ No ▢

Any prenatal, birth, or infancy concerns for yourself? Please describe. _____

_____

_____

**SUBSTANCE USE INFORMATION**

Past alcohol consumption patterns (how much, how often, how long): _____

_____

Current alcohol consumption patterns (how much, how often, how long): _____

_____

Past marijuana, K2 (ketamine), LSD, mushrooms, or methamphetamine consumption patterns (please specify which you are referring to, how much, how often, and how long): _____

_____

_____

Current marijuana, K2 (ketamine), LSD, mushrooms, or methamphetamine consumption patterns (please specify which you are referring to, how much, how often, and how long): _____

_____

_____

Past drug use patterns not specified above (how much, how often, how long): _____

_____

Current drug use patterns not specified above (how much, how often, how long): _____

_____

Past nicotine use patterns (how much, how often, how long): _____

_____

Current  nicotine use patterns (how much, how often, how long): _____

_____

Caffeine use (how much, how often, how long): _____

## PSYCHOSOCIAL HISTORY

*Educational/Occupational Background*

What is your education history and highest level completed? _____

_____

Any learning problems or learning disabilities? _____

What is your occupation and how long have you been employed in that position? _____

_____

Are you currently experiencing any impairment in educational or occupational functioning? _____

_____

*Cultural Background*

Raised by/lived with during childhood: _____

Place(s) raised: _____

Religious/spiritual background: _____

Ethnicity: _____

Cultural background (traditions, values, practices): _____

_____

*Gender and Sexuality*

Preferred pronouns:
▢ he/him
▢ she/her
▢ they/them
▢ _____

Gender:
▢ Cisgender man
▢ Cisgender woman
▢ Transgender man
▢ Transgender woman
▢ Nonbinary
▢ _____

Sexuality:
▢ Asexual
▢ Bisexual
▢ Heterosexual
▢ Homosexual
▢ Pansexual
▢ _____

*Current Background*

Briefly describe your current relationship status. _____

_____

Briefly describe your current living situation, including who lives with you. _____

_____

Are you seeking services as part of a committal? Yes ▢ No ▢

Are you currently involved in a DHS case or investigation? Yes ▢ No ▢

Are you currently involved in any legal proceedings or pending/ongoing legal cases? Yes ▢ No ▢

Briefly describe any relevant legal charges, past or present, or any relevant legal cases you have been involved in: _____

_____

_____

**FAMILY MENTAL HEALTH AND SUBSTANCE USE HISTORY**

Please indicate who in your family (excluding yourself) experienced the following and when it occurred.

▢ Active Combat _____
▢ Adoption _____
▢ Alcohol Abuse _____
▢ Anxiety/Panic _____
▢ Bipolar _____
▢ Depression _____
▢ Disability _____
▢ Divorce/Separation _____
▢ Drug Abuse _____
▢ Financial Problems _____

▢ Foster Care _____
▢ Health Problems _____
▢ Incarceration _____
▢ Learning Problems _____
▢ Legal Problems _____
▢ Natural Disaster _____
▢ Other deaths _____
▢ Other mental illness _____
▢ Parental Violence _____
▢ Physical Abuse _____
▢ Psychiatric hospitalization _____
▢ Rape _____
▢ Relationship Problems _____
▢ Schizophrenia _____
▢ Sexual Abuse _____
▢ Suicide _____
▢ Work Problems _____

Please check any of the following that apply to yourself.

▢ Abdominal problems
▢ Aches/pains
▢ Alcohol or drug abuse problems
▢ Anger
▢ Anxiety/panic/worry
▢ Binge/purge food
▢ Boredom
▢ Changes in sleep pattern
▢ Communication difficulties
▢ Concern about sexuality
▢ Confusion
▢ Crying spells
▢ Cutting, burning, or other self-harm
▢ Depending too much on others
▢ Depression
▢ Difficulties coping with daily demands
▢ Difficulties making decisions
▢ Difficulties trusting others
▢ Disorganization
▢ Disturbing fears
▢ Fatigue
▢ Fear
▢ Feeling inadequate
▢ Financial concerns
▢ Frustration
▢ General unhappiness
▢ Grief
▢ Guilt
▢ Headaches
▢Hearing voices/seeing things others don't see/hear
▢ Inability to stop doing certain things
▢ Legal issues
▢ Loneliness
▢ Low energy
▢ Memory lapses/blank periods
▢ Mood swings
▢ Nightmares
▢ Panic attacks
▢ Physical problems/pain
▢ Poor motivation
▢ Problems at work
▢ Relationship problems
▢ Restlessness
▢ Restrict food
▢ Secrets I'm afraid to tell
▢ Shame
▢ Shyness
▢ Stress
▢ Sudden impulses
▢ Suicidal thoughts
▢ Thoughts of hurting others
▢ Unable to concentrate
▢ Unwanted memories or images
▢ Unwanted thoughts/rituals
▢ Weight gain
▢ Weight loss

**RISK ASSESSMENT**

Have you had any previous thoughts or urges to harm yourself or someone else? Yes ▢ No ▢

If yes, please describe. _____

Have you had any previous suicide attempts? Yes ▢ No ▢

If yes, please describe (when, method, dates of hospitalizations). _____

_____

Have you had any previous attempts to physically harm someone else or others? Yes ▢ No ▢

If yes, please describe this incident. _____

Have you been the victim or perpetrator of any domestically abusive or violent situation? Yes ▢ No ▢
If yes, please describe. _____

Have you been the victim of any other crimes, natural disasters, or other trauma? Yes ▢ No ▢

If yes, please describe. _____

**TRAUMA AND ABUSE ASSESSMENT**

Please indicate whether you have experienced the following, and briefly describe if applicable, including the perpetrator and when the incident(s) occurred.

▢ Physical abuse _____

▢ Emotional abuse _____

▢ Sexual abuse _____

▢ Rape/assault _____

▢ Neglect _____

▢ Accidents _____

▢ Childhood losses _____