Bay Area Trauma Recovery Clinic

INDIVIDUAL INTAKE FORM

Name:_____ **Date:** _____

Home phone number: _____ **Cell phone:** _____

Is it OK for us to leave a voicemail stating we are calling from the Bay Area Trauma Clinic

…on your home number? *(Please check one):* ☐ **Yes** ☐ **No**

…on your cell phone? *(Please check one)*: ☐ **Yes** ☐ **No**

Referred by: _____

Do you know anyone currently receiving services at the clinic? ☐ **Yes** ☐ **No**

Current Address: _____ **City/State/Zip:** _____

Name of Emergency Contact person/Relation:_____

Emergency Contact Phone number: _____

The following questions will be used to help determine your fee. The Bay Area Trauma Recovery Clinic operates on a sliding fee scale. Charges range of $25-80 for individual sessions.

What is your yearly income: $ _____

How many people depend on this income: (circle one) **1 2 3 or more**

Scheduling Availability *(Please circle all that apply)***:**

Day of the week**:** M – T – W – Th – F

Time: Morning: 8am-11am Afternoon: 12pm-4pm Evening: 5pm-7pm No Preference

Please note any unusual circumstances that might affect scheduling:

_____

_____

Bay Area Trauma Recovery Clinic

Demographics/background

DOB: _____ Age: _____ Gender: ☐ F / ☐ M / ☐ Transgender / ☐ Other:

Place of Birth: _____

Please select your preferred gender pronouns: ☐ she/her/herself ☐ he/his/himself ☐ ze/hir/hirself ☐ they/them/themself

Nationality: ☐ United States ☐ Other country:_____

Ethnicity: ☐ African American ☐ Chinese ☐ Filipino ☐ Hispanic ☐ Indian ☐ Japanese ☐ Korean ☐ Latino ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Vietnamese ☐ White ☐ Two or more ethnicities *(please indicate here)* _____, _____, _____. ☐ Other ethnicity: _____

Religious or Spiritual Orientation: _____

Sexual Orientation: _____

Currently Employed: Yes ☐ / No ☐ ☐Retired ☐ Physically impaired _____

Profession/Occupation:_____

Are you a student: Yes ☐ / No ☐ ☐ Full-time Student ☐ Part-time Student

Education ☐ Did not finish High School ☐ Completed High School ☐ Some College ☐ Completed College ☐ Some Graduate School ☐ Completed Graduate School

College(s) attended (if applicable): _____

Marital Status: ☐ Single ☐ Married or in a long-term partnership ☐Divorced/Separated ☐ Widowed ☐Other _____

Do you have children? Yes ☐ No ☐ If so, age(s): _____

Housing situation

Mental Health Treatment History

Have you been in psychotherapy before? ☐ Yes ☐ No

If Yes: *(Please check all that apply)* ☐ Group ☐ Individual ☐ Couples ☐ Family

Are you currently in psychotherapy? ☐ Yes ☐ No

If No to the above questions, please skip to: Reasons for Seeking Therapy. If Yes, please answer next page:

Did you find psychotherapy helpful? ☐ Yes ☐ No

Please describe how psychotherapy was helpful or unhelpful:

_____

_____

Please list the approximate dates and reason(s) for seeking psychotherapy:

_____

_____

Are you currently taking any psychiatric medications? ☐ Yes ☐ No If yes:

Medication Name	Dosage	Frequency

Have you taken any psychiatric medications in the past? ☐ Yes ☐ No

Medication Name	Dosage	Frequency

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please describe what happened, where, duration & outcome:

_____

_____

Reasons for Seeking for Therapy

What brings you to therapy/treatment at this time

_____

_____

_____

_____

How do these problems impact or interfere with your life? _____

_____

_____

_____

How long have you struggled with these problems?

☐ **Less than one month** ☐ **1-6 months** ☐ **Less than one year**

☐ **1-5 years** ☐ **1-10 years** ☐ **Over 10 years**

Traumatic Experience(s)

Have you ever experienced a traumatic or life threatening event(s)? If yes, please briefly describe the event(s), and when they occurred (please use the back of this page if more space is necessary)

1._____

_____

2._____

_____

3._____

_____

Do you experience intrusive thoughts or memories about these events? ☐ Yes ☐ No

If yes, please explain what triggers these intrusive thoughts and memories and how often they occur:

_____

_____

Have these experiences changed the way you live your life (e.g., avoiding people, places or experiences, impact on interpersonal relationships) ? ☐ Yes ☐ No

If so, how? _____

_____

_____

Have you ever been the victim of a violent crime? ☐ Yes ☐ No If yes, please describe: _____

_____

Mood

Do you have a history of depression? ☐ **Yes** ☐ **No**

_____

_____

Do you experience intense emotions or significant mood swings? ☐ **Yes** ☐ **No**

_____

_____

Have you ever experienced periods of excessive high energy, including racing thoughts, little need for sleep, fast talking, etc? ☐ **Yes** ☐ **No**

_____

_____

Anxiety

Have you ever had a panic attack or anxiety attacks? ☐Yes ☐No ☐Not sure

If yes, please describe:

_____

If any other anxiety problem exists (e.g., social anxiety, obsessive or compulsive behaviors) describe problem, frequency, intensity, and context in which it occurs:

_____

_____

Sleep

How many hours per night do you get: on average? _____ at the very least? _____ at the very most? ___

Do you experience any sleep-related difficulties? Please describe (examples include difficulty falling asleep, oversleeping, frequent waking, nightmares, sleepwalking, restless leg syndrome): _____

_____

Eating & Dietary Health

Do you believe you have an eating disorder or problems with eating that need to be addressed in therapy?

☐Yes ☐No ☐Not sure

Substance Use

Please check all substances you have used during the last 6 months, even if it was only once:

☐Alcohol	☐Nicotine (cigarettes)	☐Amphetamines	☐"Club drugs"
☐Caffeine*	☐Marijuana	☐Cocaine	☐Opiates (heroin, pain meds)
☐Hallucinogens	☐Phencyclidine (PCP)	☐Sedatives	☐Inhalants

☐Other _____

*Examples of caffeine: coffee, caffeinated energy drinks, and caffeinated teas

For any substances you checked, please indicate type, frequency, & amount of use: _____

_____

_____

Please list all substance(s) you used at any time in the past (before 6 months ago): _____

_____

Have you ever been in treatment for substance use difficulties? If yes, indicate when, duration of treatment, and outcome: _____

Mental Health History

Please complete the following chart:

Have you ever had…	Yes	No	Current	Past
Self harm behaviors (ex: intentionally cutting or burning oneself)				
Thoughts of suicide				
A plan for suicide				
Thoughts of hurting another person				
A plan to hurt someone else				

If you answered yes to any of the above questions, please describe the details/circumstances:

_____

_____

Does anyone in your family have a history of a mental or emotional health issue? Yes ☐ No ☐

Is Yes, please describe: _____

_____

Medical History

Have you ever had any of the following? If yes, please list the condition(s), what caused it, date of onset, how often you suffer from the condition(s), and severity:

☐ Cancer: _____

☐ Hospitalizations or surgeries: _____

☐ Vision or hearing problems: _____

☐ Seizures: _____

☐ Fainting spells: _____

☐ Headaches: _____

☐ Do you have a history of any cognitive or neurological problem? _____

☐ Chronic pain: _____

☐ Miscarriage or abortion: _____

☐ Other Illness/condition: _____

Do you currently take any medications for a medical condition? If yes, please indicate the name of the medication, dosage, and how often you take it: _____

Legal History

Have you ever been involved in legal issues in the past? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are you currently involved in legal issues? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you ever been arrested for a crime? ☐ Yes ☐ No

If yes, please describe: _____

Goals for Therapy

What are your goals for therapy? If you have many, please prioritize them: _____

_____

_____

_____

_____

Thank you for completing the intake packet for the Bay Area Trauma Recovery Clinic!

Your intake clinician will now review this packet with you and ask about your history and symptoms. They will also "chain" your symptoms to better help understand exactly how these symptoms show up for you.

After today, your intake clinician will integrate all of the information into a report and generate treatment recommendations. These include starting with the Emotion Efficacy Therapy group for emotion regulation, being added to the waitlist for individual sessions, or if we determine that your needs are different from the services that we are able to provide, you will be provided with referrals and alternative treatment options.

I understand my payment today is for the intake and assessment that will be conducted today and that the services provided today are not a guarantee for initiating individual or group sessions at the Bay Area Trauma Recovery Clinic.

_____ _____

Client Signature **Date**

For Clinic Use Only

Intake clinician treatment recommendations (circle all that apply):

Individual Sessions

EET Group

Post Trauma Growth and Wisdom Group

3 Session Evaluation

Referral to Another Clinic

In our clinic when we work on trauma we use different methods, but all involve visualizing and engaging with some aspect of the trauma memory. (describe exposure if needed)

Is this something that you would be open to doing in the service of overcoming these memories?

Willingness and Avoidance notes:

Intake clinician notes: