



GROUP 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 \$15-80 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:



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 & with whom do you live? _____

Reasons for Seeking for Therapy

What brings you to therapy/treatment at this time

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 ...) _____

Substance Use

Please indicate all substances you 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

Have you been in therapy before? Yes No

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

Are you in therapy currently? Yes No

If Yes to either question above, please list the approximate dates and reason(s) for seeking therapy: _____

Please provide the following information on your current or most recent mental health professionals (no one will contact the therapist without your authorization):

Therapist's name: _____ Phone number: _____

Therapist's name: _____ Phone number: _____

Please describe your experience in therapy you had (e.g. was it helpful, not helpful, and why): _____

Are you currently taking any psychiatric medications? If yes, indicate name, dosage, and frequency: _____

Have you taken any psychiatric medications in the past? If yes, indicate name, dosage, & frequency:

Have you ever been hospitalized for psychiatric reasons? If yes, please describe what happened, where, duration & outcome: _____

Please complete the following chart:

Have you ever had...	Yes	No	Current	Past
Thoughts of hurting your self				
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: _____

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 to confirm the treatments we offer meet your needs. They will also explore your symptoms to better help understand exactly how they show up for you.

After today, your intake clinician will integrate all of the information into a report and call you in ~2 weeks with treatment recommendations. Possible recommendations 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 the intake fee is for the 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: