La Luna Center
Intake Questionnaire

C O N F I D E N T I A L

Client Information

NAME: _____ **Date:** _____

DOB: _____ **Age:** _____ **eMail Address**_____

Address: _____
Street City State Zip

Phone: Home (_____) _____ **Is it ok to leave a phone message?** (please circle) No Yes

Cell (_____) _____ **Is it ok to leave a phone message?** (please circle) No Yes

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Please indicate other professionals, if any with whom you are currently working.

Name of Individual Therapist _____ **Phone #**_____

Name of Physician_____ **Phone #**_____

Other Professional _____ **Phone #**_____

Please circle appropriate categories:

Citizenship: United States Other_____

Preferred Language: English Other_____

School Information: (if applicable)

School Name: _____

Class: Freshman Sophomore Junior Senior Graduate Other: _____

Highest Level of Education: None High School/GED Associates Bachelors Graduate

Employment Information: (if applicable)

Employment: Full time Part time # of Hours/week _____

Employer: _____

Residence: With Family With Spouse/Partner Alone Roommates Other: _____

Referred by: Self Other (Name) _____

Health Insurance Information

Insurance Company Name : _____**Member ID number:** _____

Phone number for Mental Health Benefits (usually on the back of the card) : _____

Financial Information

Financially Responsible Person: ☐ Self ☐ Other (please specify)_____**Phone #**_____

Emergency Contact:

Name:_____

Address:_____

Phone:_____ Relationship to you:_____

If a minor (under 18), who has legal custody or guardian status: _____

INTAKE QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background, in order to assist in the development of your treatment plan. Please answer all questions as fully and accurately as possible. Please note that this material is confidential and the results of this questionnaire will be released to no one outside of La Luna Center without your written permission.

Please describe yourself as fully as you feel comfortable:

How much reluctance to you have about coming in to La Luna Center today? Please circle one:

No reluctance at all Very little reluctance Some reluctance Quite a bit of reluctance Strong reluctance

If more than one applies to you, please check all that apply:

Gender	*Relationship Status*	*Sexual Orientation*	*Ethnicity/Race*
____Male	____Single	____Bi-Sexual	____ African-American
____Female	____Married or Partnered	____ Queer	____ Arab American
____Transgender	____Separated	____Gay or Lesbian	____ Asian or Pacific Islander
__ MTF	____Divorced	____Heterosexual	____ White, Non-Hispanic
__ FTM	____Widowed	____Questioning	____ Chicano, Latino, Hispanic
____ Intersex	____Other_____		____ Native or Alaskan Native
			____Other_____

Culture you most identify with:
Religious affiliation/ Spirituality:
Do you identify as having a disability? No Yes (please specify)

In addition to your eating concerns, please check all issues that currently concern you:

- ☐ Depression
- ☐ Bipolar (Mania -Depression)
- ☐ Anxiety
- ☐ Alcohol Use
- ☐ Substance Use
- ☐ Attention Deficit Disorder
- ☐ Self-understanding
- ☐ Self-acceptance
- ☐ Self-care (hygiene, taking time for self)
- ☐ Good Decision Making
- ☐ Assertiveness
- ☐ Stress Management
- ☐ Grief
- ☐ Working Through a Traumatic Event(s)
- ☐ Clarification of Own Values
- ☐ Sexual Health Issues
- ☐ Understanding Own Sexuality
  - ☐ coming-out ☐ sexual orientation ☐ gender identity
- ☐ Adjusting to School/Work
- ☐ Improved Relationships with:
  - ☐ Friends ☐ Partner ☐ Family
- ☐ Issues of Racial/Ethnic Identity
- ☐ Understanding My Impact on Others
- ☐ Decreasing Own Suicidal Thoughts
- ☐ Eliminating/Reducing Unhealthy Behavior
- ☐ Academic/Work Problems

Please check all the following symptoms that you have experienced:

☐ = Recent (within the last month) ○ = Past (one month ago or longer)

- ☐ ○ change in appetite
- ☐ ○ significant weight gain/loss
- ☐ ○ change in mood
- ☐ ○ irritability
- ☐ ○ feelings of worthlessness
- ☐ ○ changes in sleeping patterns
- ☐ ○ loss of energy
- ☐ ○ loss of interest in activities
- ☐ ○ loss or decrease in sexual interest
- ☐ ○ increase of energy
- ☐ ○ difficulty concentrating
- ☐ ○ nightmares
- ☐ ○ substance abuse (alcohol or drugs)
- ☐ ○ problems with attention, motivation, memory
- ☐ ○ recurrent and excessive anxiety or worry
- ☐ ○ feelings of restlessness
- ☐ ○ trembling or shaking
- ☐ ○ accelerated heart rate
- ☐ ○ shortness of breath
- ☐ ○ sweating
- ☐ ○ chest pain
- ☐ ○ feelings of choking
- ☐ ○ nausea
- ☐ ○ recurrent thoughts of death
- ☐ ○ recurrent thoughts of wanting to commit suicide
- ☐ ○ recurrent thoughts of harming others
- ☐ ○ cutting or burning myself
- ☐ ○ seeing things that others do not
- ☐ ○ hearing voices that others do not
- ☐ ○ paranoid thoughts

HISTORY OF EATING /BODY IMAGE CONCERNS:

Please estimate the severity of your disordered eating (check):
□Mildly upsetting □Moderately severe □Very severe □Incapacitating

When did you start to struggle with eating?

Give a brief account of the history and development of this struggle:

Describe a typical current day in your relationship with food (behaviors and frequency):

What do you think is presently causing your disordered eating?

What strengths do you bring to this problem which will assist you in overcoming it?

How would your life be different if you didn't have an eating disorder?

What are your short and long term goals for treatment?

DESCRIBE YOUR CURRENT FUNCTIONING:

Currently, I am able to…	n/a	Never	Rarely	Sometimes	Frequently	Always
attend work/classes						
concentrate on duties /tasks/assignments						
maintain employment						
maintain satisfying relationship w/ significant other						
maintain satisfying relationships w/ family members						
initiate & maintain satisfying social relationships w/ peers						
take care of my self & participate in social/recreational activities						
decide on plans for future						
demonstrate adequate coping skills, esp under increased stress						
seek assistance when stress and problems are not manageable						
decrease substance abuse and/or other high-risk behaviors						

Are you thinking about leaving your job or school? No Yes

Are you at risk for being of being fired from your job or expelled from school? No Yes

Are you experiencing any financial stressors? No Yes (describe):

Describe your work and /or academic performance:

Describe your support systems (friends, family, spiritual or cultural groups, etc.):

Describe your past and current levels of exercise or physical activity:

Describe your current interests, hobbies and activities:

PERTINENT PERSONAL/FAMILY HISTORY: (Please fill in information about yourself and your family members)

	Biological?	*Age*	*Occupation*	*Mental Health Concerns*	*Physical Health Concerns*	*Medical Concerns*
You	n/a					
Parent	Y N					
Parent	Y N					
Parent	Y N					
Parent	Y N					
Brother/Sister	Y N					
Brother/Sister	Y N					
Brother/Sister	Y N					
Child M F	Y N					
Child M F	Y N					
Child M F	Y N					
Spouse/Partner	n/a					
Others						

Are your parents married / separated / divorced / remarried? If divorced, how old were you at that time?

Describe your father's personality and his attitude towards you (Past and present)

Describe your mother's personality and her attitude towards you (Past and present):

Describe the home atmosphere in which you grew up. Was it a tense or relaxed environment? Orderly or chaotic? Noisy or quiet? Did people speak openly about their problems and feelings?

Describe your relationship(s) with your sibling(s):

Describe your relationship(s) with your child/children:

Describe your relationship(s) with your partner/spouse:

Have you lost any direct family members? No Yes – Please list:

Do members of your extended family (grandparents, aunts, uncles, etc.) have a history of mental health concerns (depression, anxiety, eating disorders etc.)? No Yes – Please list:

Is there a history of alcoholism in your extended family? No Yes – Please list:

MEDICAL HISTORY

*Date of your most recent Physical Exam: _____

*Are you currently in physical pain? No Yes (describe):

Please list <u>current medications</u> (including dosage and frequency):

_____
_____
_____
_____
_____

Have you had…	*Recently (if yes, describe)*	*Past (if yes, describe)*
a head injury?	N Y	N Y
a seizure?	N Y	N Y
loss of consciousness?	N Y	N Y
*fainting?	N Y	N Y
*cardiac conditions?	N Y	N Y
*vomiting blood?	N Y	N Y
*laxative abuse?	N Y	N Y
*abnormal bloodwork?	N Y	N Y
*diabetes?	N Y	N Y
known allergies?	N Y	N Y
significant injuries or illness?	N Y	N Y
hospitalization for a medical condition?	N Y	N Y

PREVIOUS MENTAL HEALTH TREATMENT

Age	With Whom	How Long	Focus of Treatment	Helpful?	List Medications
				N Y	
				N Y	
				N Y	
				N Y	

Have you ever been hospitalized for mental health treatment? No Yes If yes, was it voluntary? No Yes

SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

Have you ever had…	*Current (if yes, describe)*	*Past (if yes, describe)*
***thoughts of hurting yourself?	N Y	N Y
***thoughts of suicide?	N Y	N Y
****a plan for suicide?	N Y	N Y
an attempted suicide?	N Y	N Y
thoughts of hurting someone else?	N Y	N Y
an incident of actually hurting someone else?	N Y	N Y

If yes to any *** questions above, what are some of the things or people that prevent you from self-harm?

TRAUMA HISTORY

Have you ever been a victim of a crime? No Yes

Physical (e.g., car accidents, assault, abuse, head trauma, witnessing violence)

Emotional (e.g., victim of crime, abuse, loss or death of relative / friend)

Sexual (e.g., sexual harassment, sexual assault)

LEGAL HISTORY: Have you ever been arrested or convicted of a legal violation? No Yes (describe)

Are you currently involved in legal proceedings? If yes, will that impact your treatment at La Luna Center?

SEXUAL ACTIVITY: Are you sexually active? No Yes

Do you use latex condoms or other safer sex techniques every time to prevent sexually transmitted diseases? No Yes

SUBSTANCE USE HISTORY: Please indicate your use of the following substances:

	List	Current Use		Past Use	
		Frequency # of days of the week	Amount Per Day	Frequency # of days of the week	Amount of Use Per Day
Alcohol		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Marijuana		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine		0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

Any other addictive behaviors? (gambling, shopping, etc):

Thank you for completing the intake questionnaire.