PERMIAN BASIN
COUNSELING & GUIDANCE

Date: _____

Adult Intake Form

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Client Information

Last Name_____First Name_____Middle Initial____

Birth Date_____/_____/_____Social Security Number _____

Street Address_____Apt #_____

City_____State_____Zip_____Home phone_____

Cell phone_____Email_____

Who referred you?_____

Are you seeking counseling due to a court order, criminal charges, or CPS? ☐ Y ☐ N

May we: ☐ Call ☐ Leave a message ☐ Text ☐ None **Prefer:** ☐ Cell ☐ Home

Gender
- ☐ Male
- ☐ Female
- ☐ Non-binary/3rd gender
- ☐ Prefer to self-describe
- ☐ Prefer not to say

Sexual Orientation
- ☐ Straight/Heterosexual
- ☐ Gay, Lesbian, or Queer
- ☐ Bisexual
- ☐ Prefer to self-describe
- ☐ Prefer not to say

Do you identify as transgender?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Preferred Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/ Their ☐ Other _____

Relationship status: ☐ Single ☐ Significant other ☐ Cohabitating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married, how long?_____If divorced/widowed, when?_____

Racial/Ethnic identity: ☐ African American ☐ Asian American ☐ Native American ☐ Pacific Islander ☐ White/Caucasian ☐ Other_____

Are you Hispanic/Latino ☐ Yes ☐ No

Emergency Contact: Name_____Contact number_____

Relationship to the client_____

Education: Highest Level of Education Completed ☐ Less than High School ☐ High school degree or equivalent ☐ Some College, but no degree ☐ Associate's Degree ☐ Bachelor's Degree ☐ Graduate Degree ☐Refused

Are you a student? ☐ Yes ☐ No

Household Income: ☐0-,9999
☐10,000-19,999
☐20,000-29,999
☐30,000-39,999
☐40,000-49,999
☐50,000-59,999
☐60,000- 69,999
☐70,000-79,999
☐80,000-89,999
☐99,999-100,000
☐100,000+
☐Refused

Employment: ❑ Employed working 1-39 hours per week ❑ Employed working more than 40 hours per week ❑ Not Employed, looking for work ❑ Not employed, NOT looking for work

❑ Retired ❑ Disabled, not able to work ❑ Refused

Employer/Position_____

Insurance Information

Primary Insurance Name: _____ Secondary Insurance Name: _____

Phone Number of Insurance: _____ Phone number of Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder Date of Birth: _____

Insurance ID: _____ Insurance ID: _____

Insurance Group Number: _____ Insurance Group Number: _____

Family Information:

Parents Mother Living (age) _____ Deceased (date) _____
Father Living (age) _____ Deceased (date) _____

Siblings How many?_____ I am the: ☐ Oldest ☐ In the Middle ☐ Youngest ☐ Only Child

Names and ages of your children_____

Names and ages of step-children_____

Who lives at home with you?_____

Have any of your children died? ☐ Y ☐ N if yes, please provide details_____

Have you or anyone in your family experienced domestic violence or abuse? ☐ Y ☐ N

Are you currently experiencing domestic violence or abuse? ☐ Y ☐ N

Religion/Denominational preference_____Congregation (if any _____

Check all that you have experienced in the last month

☐ ADHD	☐ Guilt feelings	☐ Problems with concentration
☐ Anger	☐ Hallucinations	☐ Problems with memory
☐ Anxiety	☐ Irrational fears	☐ Problems with sleep
☐ Avoid open spaces	☐ Irritability	☐ Rage
☐ Behavioral problems	☐ Isolating/withdrawn	☐ Relationship to children
☐ Change in appetite	☐ Lack of activities	☐ Relationship to parents
☐ Chronic fear	☐ Loneliness	☐ Relationship to significant other
☐ Compulsions	☐ Loss of faith in God	☐ Religious doubts
☐ Conflicts at work	☐ Loss of hope	☐ Restlessness
☐ Decreased energy/fatigue	☐ Loss of meaning in life	☐ Self-injury
☐ Decreased pleasure	☐ Muscle tension	☐ Sexual orientation
☐ Delusions	☐ Obsessions	☐ Sexual problems
☐ Depression	☐ Other/Explain below	☐ Significant weight change
☐ Easily distracted	☐ Panic Attacks	☐ Stress
☐ Excessive worry	☐ Phobias	☐ Substance use problems
☐ Feel like I'm losing control	☐ Plans to harm self	☐ Thoughts of death
☐ Feelings of worthlessness	☐ Plans to harming others	☐ Thoughts of harming others
☐ Gender identity issues	☐ Problems due to abuse/trauma	☐ Thoughts of suicide
☐ Grief	☐ Problems in school	

Mental Health History

Have you experienced mental health problems before? ☐ Y ☐ N If yes, explain_____

Do you have a family history of mental health problems? ☐ Y ☐ N

Have you ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

☐ Y ☐ N If yes, when and where?_____

Have you ever been hospitalized or received inpatient treatment for mental health issues? ☐ Y ☐ N If yes, when and where?_____

Have you ever lost someone you care about to suicide? ☐ Y ☐ N

If yes, who and when?_____

Medical History of Client

Primary Physician_____ Date of last medical examination_____

List any physical illness or symptoms you are having at this time_____

List major surgeries or illnesses in the last five years_____

List current medications (include dosages and physician prescribing)_____

Substance Use History

Do you drink alcohol? ☐ Y ☐ N On average, how many drinks do you have?_____ per _____
quantity & type *day/week/month*

Do you use drugs (illegal drugs, recreational drugs, drugs not prescribed to you or used in excess of how they are prescribed)? ☐ Y ☐ N If yes, which ones?_____

How often?_____ per_____ IV drug use? ☐ Y ☐ N
quantity & drug *day/week/month*

Have you ever received outpatient treatment (counseling, therapy, psychiatrist, or medication) for a drug or alcohol problem? ☐ Y ☐ N If yes, when and where?_____

Completed successfully? ☐ Y ☐ N

Have you ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem?

☐ Y ☐ N If yes, when and where?_____

_____ Completed successfully? ☐ Y ☐ N

What other information is important for your therapist to know?_

Telehealth/TeleCounseling

Telehealth/Telecounseling refers to diagnosis, consultation, billing, client education, and professional education/training delivered via electronic technology. This allows clinicians at Permian Basin Counseling & Guidance to connect with clients using interactive video/audio data communication. One benefit is that the client and clinician can engage in services without physically being in the same location. This can be beneficial if the client moves to a different location or is unable to meet in person for appointments. It can also serve as an opportunity for treatment that may not be accessible for the client in their location.

Some of the PBCG therapists practice both face to face and telecounseling means for appointments, please visit with the receptionists to determine if these options are available to you. On occasion, appointments may be switched between the two types of sessions if appropriate and both parties have the capacity.

Crisis Management Plan:

I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my session, my therapist has the right to contact the following individuals for additional assistance:

1) Personal Contact:_____

   Phone Number(s):_____

2) Personal Contact: _____

   Phone Number(s):_____

3) Professional Contact:_____

   Phone Number(s):_____

I understand if deemed necessary, my therapist may request a Welfare Check to be completed, contact local authorities and/or 911. Lastly, my therapist may also make recommendations for alternative treatment or refer me for a next available crisis appointment with PBCG staff.

Acknowledgement of these forms

The information written on this packet is accurate, to the best of my knowledge.

_____ _____

Signature of Client Date

Patient Health Questionnaire- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Circle your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

If you circled <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?

(Circle your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	○	○	○	○
2. Not being able to stop or control worrying	○	○	○	○
3. Worrying too much about different things	○	○	○	○
4. Trouble relaxing	○	○	○	○
5. Being so restless that it is hard to sit still	○	○	○	○
6. Becoming easily annoyed or irritable	○	○	○	○
7. Feeling afraid as if something awful might happen	○	○	○	○

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

PCL-5 with Criterion A

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so):

How long ago did it happen?_____(please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

_____ Yes

_____ No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural causes

_____ Not applicable (the event did not involve the death of a close family member or close friend)

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

COLUMBIA-SUICIDE SEVERITY RATING SCALE

	In The Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		

	In the Past 3 Months	
6) ***Have you done any of the following?***		
Attempted to kill yourself even if ending your life was only part of your motivation		
Started to do something to end your life but someone or something stopped you before you actually did anything		
Started to do something to end your life but you stopped yourself before you actually did anything		
Taken any steps towards making a suicide attempt or preparing to kill yourself Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. ***In your entire lifetime, how many times have you done any of these things?***		

Date: _____

Military Program Eligibility Form

The information requested on this form will be used to help determine eligibility for services provided to U.S. military service members and their families. Please fill out the form as completely as possible.

Client's First Name_____Last Name_____

1. Has the client ever served in the U.S. Military? ☐ Y ☐ N

What is your current military status?

☐ Active Duty
☐ Prior Service
☐ National Guard/Reserves

2. Is the client related to any of the following who have ever served/or are currently in the U.S. military? ☐ Y ☐ N

☐ Spouse
☐ Parent

If you answered no to questions 1 or 2, you do not have to continue this form.

3. Please fill out the below for yourself the veteran sponsor's information:

a. Dates of service: from_____to_____

b. Service Connected Disability ☐ Y ☐ N

c. Rank ☐ Enlisted ☐ Officer ☐ Warrant Officer

d. Branch ☐ Navy ☐ Marine ☐ Army ☐ Coast Guard ☐ Air Force ☐ Space Force

Eligibility of military or dependent status established by following documentation

Individuals requesting services and claiming eligibility without documentation will be granted eligibility for 3 sessions. This allows the veteran or family member to acquire proof of military affiliation. Please see example of documents below needed to verify eligibility. If individual is a family member, eligibility of the service member and the relationship to the service member is required by our grant funding this program.

Veterans

- ☐ DD Form 214, Certificate of Release or Discharge from Active Duty
- ☐ NGB-22, National Guard Report of Separation and Record of Service
- ☐ NA Form 13038, Certification of Military Service
- ☐ Department of Veterans Affairs (VA) official letter or disability letter
- ☐ E-Benefits summary letter
- ☐ Uniform Services Identification Card
- ☐ State of Texas Issued Driver License with Veteran designation
- ☐ Certificate verifying Active Duty Status from Department of Defense Manpower Data Center (ONLY – currently serving active duty)
- ☐ Tricare, Triwest, or CHAMP VA insurance

Family Member

- ☐ Uniform Services Identification Card
- ☐ Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Birth Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Adoption Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Tricare, Triwest, or CHAMP VA insurance

Surviving Spouse

- ☐ Uniform Services Identification Card
- ☐ Marriage Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Death Certificate - Must have one of the above with sponsors' proof of Veteran Status
- ☐ Tricare, Triwest, or CHAMP VA insurance

Copy of eligibility documents provided and included in chart
Alert has been created in chart stating "needs military documentation".

Staff Member_____ **Date** _____