



Thank you for entrusting us with your care. We look forward to helping you through this season of your life. This intake questionnaire is intended for the counselor to get to know you better and provide you with the best possible care.

Please be advised the office coordinator will obtain authorization prior to scheduling your first appointment with the counselor. Patient financial responsibility may vary based on the estimate provided to you before your appointment. We encourage you to call your insurance provider if you have further questions regarding your benefits. Also, be advised the Lifestyle Clinic is a hospital outpatient behavioral health office. We are not a physician office. If you have questions about your appointment, please call 407-303-3818.

DIRECTIONS

Our address is **400 Celebration Place Celebration, FL 34747**. You may use our free valet service the day of your appointment or park in the parking garage. We are located on the third floor of AdventHealth Celebration hospital. Please enter the main lobby and proceed to the "A" elevators. Take the elevator to the third floor and exit left. The Lifestyle Clinic will be through the second set of doors on the right side. Continue down the hall, past the restrooms and our office will be on your left.

CLINICAL COUNSELING AGREEMENT

Confidentiality Policy and Mandatory Reporting

All therapeutic communications, records, and contact with professional and support staff will be held in confidence. Information may be released, in accordance with state law, only when (1) client signs a written release of information indicating informed consent to such release; (2) the client expresses serious intent to harm himself/herself or someone else; (3) there is evidence or reasonable suspicion of abuse against a minor child, elder person, or dependent child; or (4) a subpoena or other court order is received directing the disclosure of information.

Patients with any concerns or questions about this policy agree to raise them with the counselor at the earliest possible time to resolve them in the patient's best interest.

If I can't make my appointment, I will contact the office at 407-303-3818 within 24 hours.

We, the undersigned, counselor and patient, have read, discussed together and fully understand this agreement and the stated policies. We have agreed to the initial definition of the therapeutic process.

I understand the Clinical Counseling Agreement and Confidentiality Policy.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Counselor Signature _____ Date _____



PERSONAL INFORMATION

PATIENT'S NAME: _____ NICKNAME: _____

BIRTHDATE: _____ AGE: _____ GENDER: _____ MARITAL STATUS: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MAY WE LEAVE A MESSAGE? Yes No

CELL PHONE: _____ MAY WE LEAVE A MESSAGE? Yes No

EMAIL: _____ MAY WE EMAIL YOU? Yes No

Please note: Email correspondence is not considered to be a confidential medium of communication.

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

OTHER MEMBERS OF HOUSEHOLD:

NAME:	AGE:	RELATIONSHIP:

REFERRED BY: _____

EMPLOYER / JOB INFORMATION

EMPLOYER: _____ PHONE: _____

WHAT IS YOUR OCCUPATION? _____

LENGTH OF EMPLOYMENT WITH CURRENT EMPLOYER: _____

PLEASE INDICATE YOUR LEVEL OF SATISFACTION WITH YOUR CURRENT JOB:

Highly Satisfied Satisfied Dissatisfied

RELATIONSHIP WITH YOUR SUPERVISOR: Good Fair Poor

RELATIONSHIP WITH YOUR CO-WORKERS: Good Fair Poor

HOW MANY JOBS HAVE YOU HAD IN THE PREVIOUS 24 MONTHS? _____

DID YOU SERVE IN THE MILITARY? Yes No

BRANCH: _____ DATE OF SERVICE, FROM: _____ TO: _____



EDUCATION

ARE YOU CURRENTLY IN A SCHOOL OR TRAINING PROGRAM? Yes No

HIGHEST GRADE LEVEL COMPLETED: _____

DID YOU ATTEND COLLEGE OR VOCATIONAL PROGRAM? _____

MAJOR: _____

NAME OF SCHOOL/PROGRAM: _____ DEGREE: _____

WHAT IS YOUR CURRENT LEVEL OF PERFORMANCE IN THIS PROGRAM?

Good Fair Poor N/A

WHAT KINDS OF GRADES DID YOU GET IN SCHOOL? _____

DID YOU HAVE DISCIPLINARY PROBLEMS IN SCHOOL? _____

IF YES, PLEASE EXPLAIN: _____

MEDICAL DATA & HISTORY

YOUR PRESENT STATE OF HEALTH IS: Good Fair Poor

ARE YOU CURRENTLY UNDER TREATMENT FOR ANY MEDICAL CONDITION? Yes No

IF YES, PLEASE EXPLAIN: _____

PLEASE LIST ANY MAJOR ILLNESSES, SURGERIES AND/OR HOSPITALIZATIONS YOU HAVE HAD

AND YOUR AGE AT THE TIME: _____

HAVE YOU RECEIVED COUNSELING SERVICES IN THE PAST (INPATIENT OR OUTPATIENT)? Yes No

IF YES, PLEASE EXPLAIN (INCLUDING DATES): _____

ON AVERAGE, HOW MANY HOURS SLEEP DO YOU GET PER NIGHT? _____

DO YOU FEEL WELL RESTED AFTER SLEEPING EACH NIGHT? Yes No

ON AVERAGE, HOW OFTEN DO YOU WAKE UP DURING THE NIGHT? _____

WHEN WERE YOU LAST SEEN BY YOUR FAMILY PHYSICIAN? _____



NAME OF FAMILY PHYSICIAN: _____

DO YOU GIVE US PERMISSION TO UPDATE YOUR FAMILY PHYSICIAN? Yes No

ARE YOU CURRENTLY TAKING OR HAVE YOU BEEN PRESCRIBED ANY MEDICATION FOR PSYCHOLOGICAL OR PSYCHIATRIC REASONS? Yes No

IF YES, PLEASE EXPLAIN:

MEDICATION NAME:	DOSAGE:	REASON PRESCRIBED:	PRESCRIBED BY:	EFFECT OF MEDICATION:

LIST ANY OTHER MEDICATIONS (PRESCRIBED OR OVER-THE-COUNTER) YOU ARE CURRENTLY TAKING

(You may also bring a list of your current medications with the dosage and reason for taking):

MEDICATION NAME:	DOSAGE:	REASON PRESCRIBED:	PRESCRIBED BY:	EFFECT OF MEDICATION:

I USE (OR HAVE USED) THE FOLLOWING — CHECK ALL THAT APPLY:

	Used In Last 48 Hours	Used In Last Month	Have Used Before
Caffeine (coffee, tea, cola)			
Methamphetamines			
Alcohol			
Tranquilizers or sedatives			
Diet pills			
Marijuana			
LSD or other hallucinogens			
Cocaine			
Nicotine			
Pain Killers (not as prescribed):			
Other:			



PLEASE COMPLETE THE FOLLOWING SENTENCES, FILLING IN THE NAME OF DRUGS USED MOST OFTEN:

I USE: _____

- Once per month
- Once per week
- More than once per week
- Daily
- Several times daily

I USE: _____

- Once per month
- Once per week
- More than once per week
- Daily
- Several times daily

I USE ALCOHOL: _____

- Once per month
- Once per week
- More than once per week
- Daily
- Several times daily

DO YOU (OR OTHERS) THINK YOU NOW HAVE A PROBLEM WITH ANY OF THE SUBSTANCES YOU CHECKED ON THE PREVIOUS PAGE? Yes No

IF YES, PLEASE SPECIFY THE SUBSTANCE(S) AND STATE WHO THINKS SO:

PLEASE CHECK ANY OF THE FOLLOWING WHICH HAVE HAPPENED TO YOU WHILE USING ALCOHOL, DRUGS OR MEDICATIONS:

	ALCOHOL	DRUGS	MEDICATION
I have lost consciousness or did not know what was happening.			
I have had a fit or convulsion.			
I have been hospitalized for: _____			
I have had other treatment for: _____			



SOLUTION FOCUSED SAFETY ASSESSMENT (SFSA)

HAVE YOU EVER HAD TO COPE WITH PRIOR SUICIDAL IDEATIONS OR BEHAVIORS? _____
 IF YES, PLEASE EXPLAIN AS BEST AS POSSIBLE IN THE QUESTIONS BELOW. IF NO, PLEASE MOVE ON TO THE NEXT SECTION.

HOW DID YOU COPE? _____

WHAT KEPT YOU FROM ACTING ON THOSE THOUGHTS? _____

WHAT DO YOU NEED TO MANAGE THESE THOUGHTS? _____

DO YOU HAVE ACCESS TO GUNS OR UNLOCKED MEDICATIONS IN YOUR HOME? _____

WHAT DO YOU KNOW IS NEEDED TO MANAGE THESE MEANS OF HARM? _____

HOW CONFIDENT ARE YOU ON A SCALE FROM 1-10 THAT YOU CAN DO WHAT IS NEEDED TO MINIMIZE THESE LETHAL MEANS? _____

HOW CONFIDENT ARE YOU THAT YOU CAN CALL AND ASK FOR HELP IF YOU ARE NOT FEELING CONFIDENT IN YOUR SAFETY? _____

WHOSE PHONE NUMBERS ARE MOST IMPORTANT FOR YOU TO HAVE? _____

FAMILY & SOCIAL DATA / HISTORY

PLEASE CHECK ALL OF THE FOLLOWING THAT HAVE OCCURRED IN YOUR FAMILY AND IDENTIFY WHICH FAMILY MEMBER(S):

- _____ Alcoholism _____
- _____ Arthritis _____
- _____ Autoimmune Disorders, i.e. Crohns Disease, Lupus, Thyroid disease _____
- _____ Cancer _____
- _____ Chronic Pain _____
- _____ Diabetes _____
- _____ Drug Abuse _____
- _____ Epilepsy _____
- _____ Heart trouble _____
- _____ High blood pressure _____
- _____ Mental illness _____
- _____ Stroke _____
- _____ Suicide _____
- _____ Tuberculosis _____
- _____ Other _____



DID EITHER OF YOUR PARENTS DIE DURING YOUR CHILDHOOD OR ADOLESCENCE?

No

Yes: My mother died when I was _____ years old.

Yes: My father died when I was _____ years old.

Unknown

CHECK ALL PERSONS WITH WHOM YOU LIVED WHILE GROWING UP AND INDICATE YOUR RELATIONSHIP WITH THEM AT THIS TIME:

	GOOD	FAIR	POOR
Natural mother	_____	_____	_____
Natural father	_____	_____	_____
Stepmother	_____	_____	_____
Stepfather	_____	_____	_____
Adoptive parents	_____	_____	_____
Foster parents	_____	_____	_____
Brothers (list)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters (list)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other relatives (list)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____



Foster Home/Residential Treatment Center

AS A CHILD, WERE YOU ABUSED? Yes No

IF YES, PLEASE SPECIFY TYPE OF ABUSE (i.e. physical, emotional or sexual) AND THE ABUSER.

PLEASE CHECK ANY OF THE FOLLOWING WHICH DESCRIBE THE ATMOSPHERE IN YOUR HOME WHEN YOU WERE A CHILD:

<input type="checkbox"/> Trusting	<input type="checkbox"/> Happy	<input type="checkbox"/> Quarreling
<input type="checkbox"/> Unhappy	<input type="checkbox"/> Rigid	<input type="checkbox"/> Understanding
<input type="checkbox"/> Loving	<input type="checkbox"/> Secure	<input type="checkbox"/> Insecure
<input type="checkbox"/> Cold	<input type="checkbox"/> Casual	

WHEN YOU WERE A CHILD DID YOU PARTICIPATE IN SCHOOL ACTIVITIES, CHURCH ACTIVITIES OR CLUBS? Yes, many Yes, few None

PLEASE CHECK ANY OF THE FOLLOWING WHICH DESCRIBE YOU AS A CHILD:

<input type="checkbox"/> Nightmares	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Thumb sucking
<input type="checkbox"/> Nail biting	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Stealing	<input type="checkbox"/> Fire setting	<input type="checkbox"/> Daydreaming
<input type="checkbox"/> Running away	<input type="checkbox"/> Lying	<input type="checkbox"/> Cruelty to animals
<input type="checkbox"/> Bullying	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Head banging	<input type="checkbox"/> Picked on	<input type="checkbox"/> Bed wetting



LIST ALL PEOPLE WITH WHOM YOU NOW LIVE AND CHECK THE BOX WHICH BEST DESCRIBES YOUR RELATIONSHIP WITH THEM:

NAME	RELATIONSHIP	GOOD	FAIR	POOR

LIST YOUR FAMILY MEMBERS WHO NO LONGER LIVE WITH YOU AND CHECK THE BOX WHICH BEST DESCRIBES YOUR RELATIONSHIP WITH THEM:

NAME	RELATIONSHIP	GOOD	FAIR	POOR

I BEGAN GOING ON DATES WHEN I WAS ____ YEARS OLD.

I BECAME INTERESTED IN SEX:

Before age 12 After age 20
 Between ages 12 and 16 Never interested
 Between ages 16 and 20

I WOULD CLASSIFY MY SEXUAL PREFERENCE AS:

Heterosexual
 Bisexual
 Homosexual Other (specify) _____



BEFORE I GOT MARRIED, I DATED OR WAS INTERESTED IN:

Many boys / girls Had not dated at all
 A few boys / girls I've never been married
 Only the one I married

I AM NOW (CHECK ALL THAT APPLY):

Married Living alone
 Separated Living with family
 Divorced Living with friends
 Widowed Other (explain) _____
 Living with partner but not married
 Remarried

MY RELATIONSHIP WITH MY CURRENT MATE:

Excellent Poor
 Good Very poor

I NOW HAVE:

No close friends Several close friends (same sex)
 Only one close friend (same sex) Several close friends (opposite sex)
 Only one close friend (opposite sex) Several close friends (both sexes)

I BELONG TO:

No church, club or other social groups
 One group or church (specify) _____
 Several groups (specify) _____

I GET TOGETHER WITH FRIENDS OR OTHERS SOCIALLY:

Never Fairly often (at least once per week)
 Seldom Very often (more than once per week)

IN THE PAST YEAR I HAVE ENGAGED IN THE FOLLOWING ACTIVITIES:

<input type="checkbox"/> Reading	<input type="checkbox"/> Fishing	<input type="checkbox"/> Writing	<input type="checkbox"/> Listening to music
<input type="checkbox"/> Dancing	<input type="checkbox"/> Bowling	<input type="checkbox"/> Jogging	<input type="checkbox"/> Playing musical instruments
<input type="checkbox"/> Watching TV	<input type="checkbox"/> Swimming	<input type="checkbox"/> Drinking	<input type="checkbox"/> Watching sports events
<input type="checkbox"/> Painting	<input type="checkbox"/> Movies	<input type="checkbox"/> Gardening	<input type="checkbox"/> Shooting pool
<input type="checkbox"/> Playing cards	<input type="checkbox"/> Working on cars	<input type="checkbox"/> Gambling	<input type="checkbox"/> Surfing internet



OTHER LEISURE ACTIVITIES I ENJOY ARE: _____

DO YOU EXERCISE REGULARLY? ____ YES ____ NO

HOW MANY DAYS A WEEK DO YOU GET EXERCISE? _____

WHAT KIND OF EXERCISE DO YOU DO? _____

LEGAL INFORMATION

HAVE YOU EVER BEEN:

	NO	YES	DATES
Arrested			
Convicted			
On Probation			
On Parole			

IF YES, PLEASE EXPLAIN: _____

DO YOU HAVE A PROBATION OFFICER: ____ Yes ____ No

NAME: _____ PHONE: _____

EXPLAIN ANY LEGAL PROBLEMS YOU ARE NOW HAVING: _____

WHAT DO YOU WANT TO GET OUT OF BEING HERE TODAY? _____



HOW WOULD YOU DEFINE THE PROBLEM FOR YOU ARE SEEKING HELP? _____

HOW LONG HAS IT BEEN GOING ON? _____

HOW OFTEN DOES THIS PROBLEM AFFECT YOU? _____

WHAT ARE YOUR HOPES AND GOALS FOR COUNSELING? NAME 3 IF POSSIBLE. _____

WHAT ARE SOME OF YOUR GREATEST STRENGTHS? _____

WHAT DO YOU CONSIDER TO BE SOME OF YOUR WEAKNESSES? _____

HOW HAVE YOU LEARNED TO COPE IN THE PAST WHEN FACING A DIFFICULT OR STRESSFUL EVENT? _____

ON A SCALE FROM 1 TO 10, WHERE 1 IS THE WORST AND 10 IS THE BEST, WHERE ARE YOU TODAY? _____