AdventHealth Wellness Center Celebration

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 3rd floor of the Wellness Center, inside of AdventHealth Celebration hospital. Proceed to the main entrance of the Wellness Center and ask a representative at the front desk for the Lifestyle Clinic. We look forward to speaking with you soon.

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 therapist 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 _____

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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: _____

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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? _____

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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:			

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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: _____			

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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 FAMIILY 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 _____

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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)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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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:

_____Trusting _____Happy _____Quarreling

_____Unhappy _____Rigid _____Understanding

_____Loving _____Secure _____Insecure

_____Cold _____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:

_____Nightmares _____Temper tantrums _____Thumb sucking

_____Nail biting _____Insomnia _____Speech problems

_____Stealing _____Fire setting _____Daydreaming

_____Running away _____Lying _____Cruelty to animals

_____Bullying _____Loneliness _____Sleepwalking

_____Head banging _____Picked on _____Bed wetting

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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

_____Between ages 12 and 16

_____Between ages 16 and 20

_____After age 20

_____Never interested

I WOULD CLASSIFY MY SEXUAL PREFERENCE AS:

_____Heterosexual

_____Bisexual

_____Homosexual

_____Other (specify)_____

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

_____Many boys / girls
_____A few boys / girls
_____Only the one I married
_____Had not dated at all
_____I've never been married

I AM NOW (CHECK ALL THAT APPLY):

_____Married
_____Separated
_____Divorced
_____Widowed
_____Living with partner but not married
_____Remarried
_____Living alone
_____Living with family
_____Living with friends
_____Other (explain)_____

MY RELATIONSHIP WITH MY CURRENT MATE:

_____Excellent
_____Good
_____Poor
_____Very poor

I NOW HAVE:

_____No close friends
_____Only one close friend (same sex)
_____Only one close friend (opposite sex)
_____Several close friends (same sex)
_____Several close friends (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
_____Seldom
_____Fairly often (at least once per week)
_____Very often (more than once per week)

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

_____Reading _____Fishing _____Writing _____Listening to music
_____Dancing _____Bowling _____Jogging _____Playing musical instruments
_____Watching TV _____Swimming _____Drinking _____Watching sports events
_____Painting _____Movies _____Gardening _____Shooting pool
_____Playing cards _____Working on cars _____Gambling _____Surfing internet

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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?_____

_____

_____

_____

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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?_____

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