



Behavioral & Community Health

Recovering the Past to Protect the Future

INTAKE QUESTIONNAIRE

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

IDENTIFYING INFORMATION

Name: _____ Date of Birth: _____
(Consumer)

Address: _____ Sex: _____
_____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Household Income: _____

Who referred you to SBCH? _____

Race/Ethnicity: _____

Religious Affiliation: _____

DISABILITY

1. Do you have a disability? Yes No If yes, please specify: _____

If you have a disability, does the office accommodate your needs? Yes No

2. If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

CULTURE

1. Please describe your culture (Race, religion, or etc.)

PRESENTING PROBLEM

1. What is the primary problem for which you are seeking help?

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? Yes No
If yes when, where and with whom? _____

MENTAL HEALTH HISTORY

1. Do you have a history of mental illness?

2. Have you ever received treatment (counseling or medication) for a mental illness? If yes, explain.

3. Have you ever been hospitalized for a mental illness? If yes, please describe when, where, and by whom?

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? Yes No

2. Do you or another family member have a history of alcohol or drug problem? Yes No

If yes, please explain: _____

3. Please describe your current alcohol consumption: _____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?

Yes No If yes, please describe the circumstances: _____

5. Have you or any other family member experienced any type of abuse? Yes No

If yes, please explain: _____



LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

CURRENT FAMILY INFORMATION

1. Please provide the following information:

Name (First and Last)	Date of Birth	Lives with You?	
Spouse/Significant Other:		Yes	No
Children: _____		Yes	No
_____		Yes	No
_____		Yes	No
_____		Yes	No
Others Living in Household:			

2. Highest educational level achieved: _____

3. Military service: Yes No

4. Occupation: _____

5. Current employer: _____

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

2. Please check the appropriate box if you have experienced any of these problems:

- | | |
|---|---|
| Eye disease, injury, poor vision
Ear disease, injury, poor hearing
Nose, sinus, mouth, throat problems
Convulsions or seizures
Memory problems
Extreme tiredness or weakness
Marked weight changes
Heart disease
Back, arm, leg or joint problems
Encephalitis
Pregnancy
High blood pressure
Liver, gallbladder disease | Cancer
Bowel or Hemorrhoid problems
Head injury, loss of consciousness
Frequent or severe headaches
Sleep disturbances
Neck stiffness, pain, swelling
Skin disease
Allergies or asthma
Diabetes
Premenstrual Syndrome (PMS)
Eating disorder
Chest pain or angina pectoris
Other _____ |
|---|---|

Please explain anything checked above: _____



3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____

DEVELOPMENTAL HISTORY

1. Pregnancy and delivery were normal? Yes No I don't know

If no, please explain: _____

2. Did mother use alcohol or other drugs during pregnancy? Yes No I don't know

If yes, please explain: _____

3. Please list any medications taken during pregnancy: _____

4. Did you reach developmental milestones at a normal age:

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				
Spoke in simple phrases				
Toilet trained – day				
Toilet trained - night				

GOALS

1. What are your strengths? _____

2. What are your weaknesses? _____

3. What goals would you like to see reached as a result of your involvement with Sankofa Behavioral & Community Health?

4. How will you know when these goals have been reached?



Payment Verification

For Office Use Only

Copy of Insurance Card: Yes No

Insurance Verified (Date):

Limits Verified (Date):

Preauthorization Needed (Date):

Consumer's Name: _____

Authorization No.: _____

Insurance Company Name: _____

Address of Insurance Company: _____

Phone Number: _____

Name of Insured: _____

Birth Date of Insured: _____

Gender of Insured: Male Female

Social Security No. of Insured: _____

Effective Date of Policy: _____

Group No.: _____

Policy No.: _____

Employer of Insured: _____

Plan/Program: _____

Please initial each and sign below:

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of information to all my insurance companies.

_____ I understand that I am responsible for my bill.

_____ I authorized Sankofa Behavioral & Community Health or Valerie Henderson, Ph.D. to act as my agent in helping me to obtain payment from my insurance companies.

_____ I authorize direct payment to Sankofa Behavioral Community Health or Valerie Henderson, Ph.D.

_____ I permit a copy of this authorization to be used in place of the original.

Consumer, Parent or Guardian Signature

Date

This is strictly a confidential client medical record. Redislosure or transfer is expressly prohibited by law. The signature of a parent or legal guardian is required if the client is under 18 years of age or legal incompetent.



Office: 414.202.9146; 608.239.9589

sankofabch@gmail.com

6400 Gisholt Drive, STE 209, Monona, WI 53713