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.)

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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
☐ Cancer
☐ Bowel or Hemorrhoid problems
☐ Head injury, loss of consciousness
☐ Frequent or severe headaches
☐ Sleep disturbances

☐ Extreme tiredness or weakness
☐ Marked weight changes
☐ Heart disease
☐ Back, arm, leg or joint problems
☐ Encephalitis
☐ Pregnancy
☐ High blood pressure
☐ Liver, gallbladder disease
☐ 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: ____ / ____ / ____

Policy No.: _____ Group 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. Redisclosure 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.

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