Trauma Informed Therapies

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8. PERSONAL INFORMATION FORM

Please provide the following information for intake purposes and for our records. Leave blank any question you would rather not answer or would prefer to discuss in person with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy. For adolescent clients 13 years old and older, please have the client, not the parent/guardian, fill out and initial these documents.

Client Name (legal):

Date of Birth:

Gender Given at Birth:

Client's Gender Identity:

Client's Preferred Pronouns:

Sexual Orientation:

Client's Primary Spoken Language:

Client's Cell Phone Number:

Client's Home Phone Number:

Client's Work Phone Number:

Client's E-mail Address:

Client's Home Address:

Client's Mailing Address:

Client's Employer (Place/Name of Supervisor):

Emergency Contact Information

1) Name :

1) Relationship to you:

1) Address:

1) Phone Number:

2) Name :

2) Relationship to you:

2) Address:

2) Phone Number:

BACKGROUND

The following information helps us get a better picture of your situation, needs and concerns.

What prompted you to schedule an intake with Trauma Informed Therapies?:

Have you received therapy/counseling before?:

Have you ever been prescribed psychiatric medication (e.g. an antidepressant)? :

If yes, please describe when and for what purpose psychiatric medications were prescribed as well as dosages, if known. Include and indicate any psychiatric medications being taken currently: :

Have you ever attempted suicide?:

Have you ever been psychiatrically hospitalized? :

Do you have a current or existing crisis plan with an outpatient provider*? :

Have you ever had/have PTSD? :

Have you ever been sexually abused or witnessed sexual abuse? :

Have you ever been physically abused or witnessed physical abuse? :

Have you ever been emotionally abused or witnessed emotional abuse? :

Have you ever been neglected or witnessed neglect? :

Do you have any present or past difficulties with impulsive behaviors (check all that apply):

- [ ] Shoplifting/Stealing
- [ ] Problem/Pathological Gambling
- [ ] Compulsive Sexual Behavior
- [ ] Compulsive Shopping
- [ ] Other:

Description if Other::

Substance Use/Treatment

Do you drink alcoholic beverages? If yes, provide amount consumed per day, week, or month::

Do you currently use cannabis? If yes, provide type of ingestion and times used per day, week, or month::

Do you currently use street drugs or use any prescription drugs not as prescribed? If yes, provide type of drug used and amount consumed per day, week, or month::

Do you smoke cigarettes or use tobacco products? If yes, provide type of tobacco product used and amount consumed per day, week, or month::

Do you ingest caffeine? If yes, provide amount consumed per day, week, or month::

If you or anyone else has been concerned about your drinking or drug use, describe what help you sought/are seeking: :

Physical Health

Please describe any current or ongoing medical concerns: :

Who is your primary health care provider (i.e. physician, nurse, OB/GYN)?:

When was your last physical?:

Have you ever been hospitalized? :

Have you ever had surgery? :

Have you ever been diagnosed with a Traumatic Brain Injury (TBI)?:

Are you currently pregnant? :

If pregnant, has there been any prenatal exposure to drugs or alcohol? :

Please list any non-psychiatric prescription medications, over-the-counter drugs, vitamins, and/or herbal supplements that you currently take and dosages, if known: :

Any allergies to food, drugs, or environmental sensitivities (i.e.- sensitivity to fragrance): :

History

Where were you born and where were you raised?:

Who were your primary caregivers as a child (i.e. who raised you?):

What were your parents'/guardians' occupations when you were growing up? :

How many children are in your family of origin?:

Where do you fall in birth order (first, middle, etc.)?:

Please indicate the presence of the following conditions in your or your family's history:

- [ ] Depression
- [ ] Anxiety

- [ ] Eating Disorder
- [ ] Bipolar Disorder
- [ ] Drug/Alcohol Problems
- [ ] Suicide or Suicide Attempt
- [ ] Psychiatric Hospitalization
- [ ] Allergies
- [ ] Alzheimer’s or other Dementia
- [ ] Asthma
- [ ] Cancer
- [ ] Developmental Disability
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Heart Disease
- [ ] High Cholesterol
- [ ] High Blood Pressure
- [ ] Obesity
- [ ] Stroke
- [ ] Other Disorder:

If Other, please describe::

Current Life Situation

Present Relationship Status:

If "other" relationship status, please describe::

Who do you live with? (Name, Age, Relationship to you):

Housing Status:

If "other" housing, please describe::

Do you believe that your basic needs are being met (i.e. clothing, shelter, etc.)?:

If no, please explain:

Do you feel safe in your home? :

Do you feel you have a sufficient social support system?:

Do you confide in your support system about your problems?:

Were your developmental milestones delayed or missed (i.e. walking, toilet training, talking, etc.)? :

If yes, please explain::

What is your highest level of education?:

If "other" degree, please describe::

Do you have any current literacy / reading issues?:

If yes, please describe::

Do you need the use of assistive technology? :

If yes, please describe needs::

What is your current employment status?:

If other, please explain::

If employed, what is your current occupation?:

How satisfied are you with your current job?:

If "other" employment, please describe::

Have you ever received or do you currently receive financial assistance? If yes, please describe::

Legal History

Check any legal involvement that applies to you:

- [ ] Criminal
- [ ] Order of Protection/Restraining Order
- [ ] Commitment
- [ ] Guardianship
- [ ] Other

If any of the above were checked, please describe why::

Please check if you are currently involved with and/or have the following:

- [ ] Powers of attorney
- [ ] I am under civil or criminal court ordered mental health treatment
- [ ] Letters of guardianship / parenting plans / court order for custody
- [ ] Supervision by the department of corrections

*If answered yes to any of the questions above, please provide TIT with all relevant legal documents/paperwork

Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your service preferences: :

Please indicate your ethnicity / cultural / tribal affiliation identification: :

What areas are stressful in your life? (i.e. finances, career, relationship, health, school, etc.): :

Please describe attributes or characteristics that you view as personal strengths: :

Hobbies / Abilities / Interests: :

Is there anything else you feel it is important for us to know right now? :

Notes for any questions or comments for TIT or personal therapist: :

Past Mental Health and Treatment History:

Please include all treatment and services received within the last 5 years and any highly significant treatment received within the history of your life.

Start/End Dates / Type of Treatment / Name of Provider and Clinic / Address and Phone Number :

CLIENT INITIALS:

My initial indicates that I have read and understand the above information.

Client Initials:

Parent/Guardian Initials**:

**Required if client is a minor and under the state-mandated age of consent. Age of consent is 13 years old in the state of Washington, clients 12 years old and younger must have Parent/Guardian consent. For questions on your state's minor consent laws, please see the TIT Front Desk staff.