

**MINNESOTA RENEWAL CENTER
INTAKE**

3499 Lexington Avenue N #100, St Paul, MN 55126
Phone: 651-486-4828

FULL NAME _____ DATE _____ DOB _____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy today? _____

2. Did a specific event lead to this request for service? Yes No If yes, please describe the incident. _____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy. _____

4. How long has the problem been present? _____

5. What solutions to the problem have you tried, and what were the results? _____

6. How much does this problem affect your life? (*Please circle the number that best applies*)

	Not at all	A Little bit	A lot	All the time
1. Personally	1	2	3	4
2. Family life	1	2	3	4
3. Socially	1	2	3	4
4. Work	1	2	3	4
5. Health	1	2	3	4

7. How were you referred to this service? (*Please circle*)

Self Spouse/Other Physician Employer Court Other (*Please specify*): _____

8. Do you make use of any community-based support groups (e.g. 12-Step Programs, social support groups, etc)? Yes No If yes, please specify: _____

9. Do you have an involvement with any of the following people or services? Yes No If yes, please circle all that apply:

County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litum Worker's Compensation

If so, please describe. _____

Contributing Factors

10. Which of the following do you think contribute to your problem(s)? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Family move to a new home | <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Developmental problems |
| <input type="checkbox"/> Adjustment to sitter/day care | <input type="checkbox"/> Birth of child or sibling | <input type="checkbox"/> Suspect physical/sexual abuse |
| <input type="checkbox"/> Parental quarreling/arguing | <input type="checkbox"/> Adjustment to school | <input type="checkbox"/> Known physical/sexual abuse |
| <input type="checkbox"/> Post-divorce adjustment | <input type="checkbox"/> School problems | <input type="checkbox"/> Law violations |
| <input type="checkbox"/> Financial stress | <input type="checkbox"/> Absenting home or school | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Marital unfaithfulness | <input type="checkbox"/> Negative peer influence | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Separation of parents | <input type="checkbox"/> Medical problems | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Remarriage of parent | <input type="checkbox"/> Drugs or alcohol use | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Parenting problems | <input type="checkbox"/> Career change | <input type="checkbox"/> Empty nest |
| <input type="checkbox"/> Spiritual problems | <input type="checkbox"/> Previous therapy | <input type="checkbox"/> Other: _____ |

Symptoms

11. Please look these items over and circle the number that best describes how these symptoms have bothered you **in the past month**.

	Not at all	Mildly	Moderately	Severely
1. Depressed, sad, or crying	1	2	3	4
2. Guilty feelings	1	2	3	4
3. Suicidal thoughts, plans, or attempts Have you <i>ever</i> thought about, planned or attempted suicide? Thought about Y N Planned Y N Attempted Y N If yes to any of these, when was this? _____	1	2	3	4
4. Changed sleep patterns <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep <input type="checkbox"/> Can't get up in a.m. <input type="checkbox"/> Nightmares	1	2	3	4
5. Change in weight or eating habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
6. Loss of interest or energy	1	2	3	4
7. Anxious, nervous, or panicky feelings	1	2	3	4
8. Avoiding places or situation	1	2	3	4
9. Repetitive thoughts or behaviors	1	2	3	4
10. Change in work habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
11. Anger or temper problems	1	2	3	4
12. Insecurity or inferiority	1	2	3	4
13. Physical problems, pain, or illness	1	2	3	4
14. Sexual worries or problems	1	2	3	4
15. Change in spending habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
16. Memory problems	1	2	3	4
17. Confused or disorganized thoughts	1	2	3	4
18. Hallucinations	1	2	3	4

Medical and Mental Health history

12. Who is your primary care physician and your primary clinic? _____

13. Who else do you regularly see as part of your routine health care? _____

14. List any significant health problems, past or present, including surgeries and/or illnesses with the *corresponding dates*.

15. Are you currently taking any medications? Yes No If yes, please list:

Medication	Dose and number of pills you take per day (e.g. .25 mg. 3 times per day)	Prescribing doctor

16. Have you ever taken any other medications for depression, anxiety, or mental health issues? Yes No If yes, please list:

Medication Name	Prescribed for? (eg: depression, anxiety)	When (approx)	How long were you on the medication?	Prescribing doctor

17. List other therapy or counseling you have received in the past or are receiving now:

Therapist's name	Location	Approximate dates

18. What has been helpful in the past in therapy _____

What has **not** been helpful _____

19. If you think it would be helpful for your therapist to contact a previous therapist or physician, you will need to sign a Release of Information form. To receive a Release of Information form, please check here .

20. Have you ever been hospitalized for mental health reasons? Yes No If yes, when and where? _____

Substance Use

21. Please describe your use of the following substances:

	Daily	Weekly	Occasionally	In the past but not now	Not at all
Caffeine					
Tobacco					
Alcohol					
Prescription drugs					
Inhalants					
Street drugs					
Over-the-counter medications					
Other: _____					

22. Have you ever had treatment for any type of alcohol or substance use? Yes No If yes, when? _____

Please describe: (Include inpatient, outpatient, detox): _____

Resources

23. What has helped you manage or endure your current problem? _____

24. Please describe the people in your life that currently play a supportive, influential, or friendship role. _____

25. What interests or passions give meaning to your life? _____

26. Do you have any spiritual beliefs or practices that are important to you? Yes No If yes, please explain: _____

27. What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of? _____

Family Information

28. Please list those who you consider part of your immediate family and/or your current household.

Name	Age	Relation to you	Living with you?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Other

29. Is there anything else that you would like your therapist to know that you have not written about on any of these forms?

Signature and Date

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform my counselor of any changes in my personal information.

Client Signature _____ Date _____