Stockbridge-Munsee Adult Patient Intake Questionnaire

Name: ____________________ **DOB:** ____________ **Today's Date:** __________

Presenting issue(why are you here? ____

____

____

Tribal Member? Yes / No What Tribe? ____________________________________

Were you referred? Yes / No By Who? ____________________________________

Employer? ____

Financial situation:____

What is your housing situation? ____

Education background: ____

Have you served in the military? Combat/PTSD? __________________________

Who is in your family? (parents,siblings,children,etc) _________________________

____

Do you have childcare for appointments? Yes / No / Not Applicable

Legal/criminal history: ____

____

Medical problems/history: ____

____

Are you getting regular medical care? Where? ____________________________

Who is your doctor? ____

What Medications do you take and for what condition? __________________

____

____

Tobacco use? Y N If yes, how much? ______________________________________

Daily food intake:(healthy, junk food, diabetic, etc) _________________________

Any concern about possible eating disorder? Yes / No

Mental health history(prior treatment, when, where, family hx, etc): ____________

____

Do you feel suicidal? Yes / No

Do you feel stable at the present time? Yes / No

What trauma/violence or abuse have you experienced? (abuse, violence domestic violence, witnessed violence, etc.) ______________________________
____

What is your grief/loss history? ______________________________
____

Do you have a history of problem gambling? Yes / No

During the past 12 months,

1) Have you ever felt the need to bet more and more money? Yes / No
2)

2) Have you ever had to lie to people important to you about how much you gambled? Yes / No

What are your cultural/spiritual practices? ______________________________
____

What are your hobbies or things you do for fun? ______________________________
____

Strengths: ____

Challenges: ____

Who's in your support network(family, friends, teachers, etc.):______________
____

How likely are you to remain in and/or complete counseling services?
(Not likely--------Somewhat likely------Likely-----Very likely)

What positive changes would you like to see happen in your life? ____________
____

What is your alcohol/drug treatment history? (prior treatment, when, where, family hx, etc): ______________________________
____
____

Alcohol/Drug Use History	What Type/Method of use?	Age of first use	How much do you use each time?	How often are you using? (Daily, weekends, monthly)	Date of last use?
Alcohol					
Cannabis					
Cocaine					
Stimulants					
Opiates					
Suboxone Subutex					
Benzos					
Hallucinogens					
Depressants					
Inhalants					
Steroids					
Synthetic Marijuana					
Over the Counter					