511 Northern Hills Dr NE, Suite #2
Rochester, MN 55906
(507) 923-7321

Intake Questionnaire
Adult Dialectical Behavior Therapy

Name: ______________________ Today's Date: ____________

Below are several standard questions we ask in order to better serve you. Provide as much detail as you would like; you can verbally provide more detail at your appointment, if you wish.

Reason for Visit

What is the reason that brought you here today?

Did someone recommend you make this appointment? If so, who? _________
and why did he/she recommend making an appointment?

Demographics

Your date of Birth: _____________ Age: ________

Identified Gender (please circle): Male Female Other:______

Identified Race: Identified Ethnicity:

County of Residence: Residential Status:

Current Life Situation

With whom do you currently live?

First name ____________ Relationship to you ________ Age _____

First name ____________ Relationship to you ________ Age _____

First name ____________ Relationship to you ________ Age _____

First name ____________ Relationship to you ________ Age _____

First name ____________ Relationship to you ________ Age _____

Are you satisfied with your current living situation? ___ YES, ___ NO, __Unsure

Do you live in an environment that is safe and free from verbal, emotional, or sexual abuse? ___ YES, ___ NO, __Unsure

What is your highest level of education?

___ Some high school (Last grade completed?) _____
___ High school graduate
___ Some college
___ College graduate
___ Some graduate level courses
___ Completed graduate degree(s)

Are you currently employed? ___ YES, ___NO, ___Student
___ Full-time, ___Part-time?

On average how many hours per week do you spend

In school:
Doing volunteer work:
Employed:

Have you ever been arrested? ____________________ YES NO

Are you currently on probation? ____________________ YES NO

Do you have any pending legal problems? ____________________ YES NO

Are you a Veteran, or have you served in the United States military? YES NO

If yes, are you receiving VA Mental Health Services? YES NO

Briefly describe your social support network. Do you feel adequately supported in your relationships? Who are your main supports?

What do we need to know about your spiritual or cultural background in order for us to be helpful to you? Please describe any spiritual/ cultural/ family influences currently impacting you and/ or the problem that brought you here today:

What makes the problem (that brought you here today) worse or harder to manage?

What is currently going well for you? What would you say are your strengths?

Medical Information

How would you describe your current physical health?

When was your last physical exam? __________
What were the results?

Who is your primary care physician? ________________________________

What primary care clinic do you use? ________________________________

What medications are you currently taking? (Please include those you are taking for both physical and/ or emotional issues. Or, you may attach a list from your clinic.)

Have you ever had a head injury? ___ YES, ___ NO
If yes, please briefly describe.

Have you had any significant childhood injuries or illnesses? ___ YES, ___ NO
If yes, please briefly describe.

As a child, were you affected by maltreatment, trauma, and/ or abuse? ___ YES, ___ NO, __Unsure

As an adult, were you affected by maltreatment, trauma, and/ or abuse? ___ YES, ___ NO, __Unsure

Treatment History

How old were you when you first received mental health services?

Have you ever participated in a DBT specific program? YES NO
If yes, (Please check all that apply) __Group therapy, __Individual therapy, __ Phone coaching.
How many years have you been in a DBT specific program?

Have you ever had thoughts of harming yourself/ someone else? ___ YES, ___ NO
Do you currently struggle with these thoughts? ___ YES, ___ NO

In the past have you attempted suicide? YES NO
If yes, please list date(s):

In the past have you engaged in non-suicidal self-injury behaviors? YES NO
If yes, please describe:

When was your most recent self-injury?____

In the past have you visited the ER for self-harm risk/injuries? YES NO

If yes, please list dates and times of visits:_________

In the past have you been hospitalized for mental health concerns? YES NO

If yes, please list dates and times of hospitalization(s):_________

In the past have you stayed at an IRTS Crisis Bed? YES NO

If yes, please list dates and times of treatment(s):

In the past have you been in an IRTS program? YES NO

If yes, please list dates and times of treatment(s) :_________

Do you currently use ___ alcohol, ___ tobacco, or ___other substances?
Do you have any concerns about your use of alcohol, tobacco, or other substances?

When answering the following questions, think about drug use including illegal drug use and the use of prescription drug use other than prescribed.

Have you ever felt that you ought to cut down on your drinking or drug use? YES NO

Have people annoyed you by criticizing your drinking or drug use? YES NO

Have you ever felt bad or guilty about your drinking or drug use? YES NO

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? YES NO

Have you ever struggled with addiction? ___ YES, ___ NO, __Unsure
If yes, please briefly describe.

Please list below the names and dates of any previous chemical or mental health treatment (not already listed above):

Name of Agency:	Reason for treatment:	Dates of treatment:

What medications (for mental health issues) have you tried in the past? What was the result?

Has anyone in your family struggled with addiction or mental health? If so, please specify:
Relationship to you Type of Problem

Goals and Preferences

What would you like to accomplish in your time here at Riverstone?

How would you describe your motivation to accomplish this/ these goals?

__I *have already made the changes* I want and only *need support in maintaining those changes*.

__I am *committed to the decision* to work on my goals. Now, I *need help to accomplish* my goals.

__I have *mixed feelings about whether I can* make any changes in my life at this time.

__I have *mixed feelings about whether I want to* make changes in my life at this time.

__I *do not currently see a need* for me to work on therapy goals at this time. I am mainly here because someone else wanted me to.

__Other: ____

Based on your past experience with counseling or treatment, what is important to you in your therapy, therapist, or counseling agency?

Thank you for taking the time to complete this questionnaire. Please return it at your next appointment.

OFFICE USE ONLY

DSM-5 Primary: ICD 10 CODE
Secondary:_ ICD 10 CODE
Tertiary: ICD 10 CODE

FAMILY
Children under 18 years old? YES NO

Children age range:

Children reside with client?	YES	NO
Children with Special Needs?	YES	NO