Riverstone Psychological Services

3800 Hwy 52 N, Suite 220
Rochester, MN 55901
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 _____

Would you like any family members to be involved in your care?___ YES, ___ NO
If so, who?

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?

Are you currently dealing with any medical conditions (e.g., diabetes, thyroid dysfunction, infections/ contagious diseases etc.)?
If so, briefly describe.

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

Who is your primary care physician? _____
If you have a primary care physician, would you like us to contact that person to coordinate care? ___ YES, ___ NO

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.)

Do you have any allergies (food, medications, environmental)?___ YES, ___ NO
If so, briefly describe.

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.

Are there specific medical conditions that run in your family? If so, please specify.

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? YES____NO

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:

_____
_____
_____
_____

_____Are you currently working with any mental health service providers? ___ YES, ___ NO
If so, would you like us to contact them to coordinate care? ___ YES, ___ NO
If so, who?

_____
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