



## 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

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Are you currently on probation? \_\_\_\_\_ YES  NO

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Do you have any pending legal problems? \_\_\_\_\_ YES  NO

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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.

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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