

Intake Packet

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Patient Registration Record

Today's Date: _____

Name: _____

Address: _____ City: _____ Zip: _____

Telephone # (home) _____ Work _____ Cell: _____

Age: _____ Birthdate: _____ Email: _____

Drivers License: State: _____ Number: _____

Physician: _____ Phone _____

Employed by: _____

Address of Employment: _____

Emergency Contact Name _____ Phone _____

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Please list how long, to all that applies below:

Married: _____ Partnered: _____ Single: _____ Separated: _____ Divorced: _____ Widowed: _____

Ethnicity: _____ Religion: _____

Name of Emergency Contact: _____ Phone #: _____

Relationship to Client: _____

Are You Currently in Other Counseling? Yes No

If Yes, Name and Address: _____

Prior Counseling, Name(s) & Date(s): _____

Current Medications / Dosages (Including Over the Counter): _____

Have You Had Any Problems with Medications? _____ If Yes, Details: _____

Any Difficulty with Drugs or Alcohol? (Legal, Relational, Occupational or Personal?) _____

Major Reason for Seeking Help at this Time? _____

How long have you had these problems or symptoms? _____

Why did you seek help now? _____

Client Initials _____

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Do You Have Any Serious or Chronic Medical Condition? _____

If Yes, Dates & Details: _____

Have You Had Any Serious Accidents/Head Injuries/Seizure Activity? _____

If Yes, Dates & Details: _____

Do you have any recurring nightmares? (Describe) _____

Who loved you unconditionally from 0 to 18 years of age? Who gave you positive reinforcement? _____

Who loves you and supports you in your life now? _____

What is your spirituality? _____

What spiritual resources do you have, if any? By what name do you call your spiritual supports? _____

What characteristics do you like most about yourself? _____

Do you have any performance goals you would like to meet? _____

Client Initials _____

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What states of being do you desire to live in or return to? (Peace, Joy, Creativity?) _____

Have you lost any parts of yourself you would really like to have back in your life? _____

Client Initials _____

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THE AMEN CLINIC QUESTIONNAIRE

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

- _____ 1. Frequent feelings of nervousness or anxiety
- _____ 2. Panic attacks
- _____ 3. Avoidance of places due to fear of having an anxiety attack
- _____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)
- _____ 5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)
- _____ 6. Tendency to predict the worst
- _____ 7. Multiple, persistent fears or phobias (dying, doing something crazy)
- _____ 8. Conflict Avoidance
- _____ 9. Excessive fear of being judged or scrutinized by others
- _____ 10. Easily startled or tendency to freeze in intense situations
- _____ 11. Seemingly shy, timid, and easily embarrassed
- _____ 12. Bites fingernails or picks skin
- _____ Total number of questions with a score of 3 or 4 for questions 1- 12 (GAD)

- _____ 13. Persistent sad or empty mood
- _____ 14. Loss of interest or pleasure from activities that are normally fun
- _____ 15. Restlessness, irritability, or excessive crying
- _____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness
- _____ 17. Sleeping too much or too little, or early morning waking
- _____ 18. Appetite changes/ weight loss or weight gain through overeating
- _____ 19. Decreased energy, fatigue, feeling "slowed down"
- _____ 20. Thoughts of death or suicide, or suicide attempts
- _____ 21. Difficulty concentrating, remembering, making decisions
- _____ 22. Physical symptoms; headaches, chronic pain, digestive problems
- _____ 23. Persistent negativity or low self esteem
- _____ 24. Persistent feeling of dissatisfaction or boredom
- _____ Total number of questions with a score of 3 or 4 for questions 13-24 (MDD)

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

- ____ 25. Excessive or senseless worrying
- ____ 26. Upset when things are out of place or don't go according to plan
- ____ 27. Tendency to be oppositional or argumentative
- ____ 28. Tendency to have repetitive negative or anxious thoughts
- ____ 29. Tendency toward compulsive behaviors
- ____ 30. Intense dislike of change
- ____ 31. Tendency to hold grudges
- ____ 32. Difficulty seeing options in situations
- ____ 33. Tendency to hold on to own opinion and not listen to others
- ____ 34. Needing to have things done a certain way or you become upset
- ____ 35. Others complain you worry too much
- ____ 36. Tendency to say no without first thinking about the question (OFA)
- ____ Total number of questions with a score of 3 or 4 for questions 25-36

- ____ 37. Periods of abnormally happy, depressed or anxious mood
- ____ 38. Periods of decreased need for sleep, energetic on much less sleep
- ____ 39. Periods of grandiose thoughts and ideas (feeling very powerful)
- ____ 40. Periods of increased talking or pressured speech
- ____ 41. Periods of too many thoughts racing through your mind
- ____ 42. Periods of increased energy level
- ____ 43. Periods of poor judgment that leads to risk-taking behaviors
- ____ 44. Periods of inappropriate social behavior
- ____ 45. Periods of irritability or aggression
- ____ 46. Periods of delusional or psychotic thinking
- ____ Total number of questions with a score of 3 or 4 for questions 37 – 46 (BD)

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

- ____ 47. Short fuse or periods of extreme irritability
- ____ 48. Periods of rage without being provoked
- ____ 49. Often misinterprets comments as negative when they are not
- ____ 50. Periods of spaciness or confusion
- ____ 51. Periods of panic or fear for no specific reason
- ____ 52. Visual or auditory changes (seeing shadows or hearing sounds)
- ____ 53. Frequent periods of déjà vu (feeling you've been somewhere you have never been)
- ____ 54. Sensitivity or mild paranoia
- ____ 55. Headaches or abdominal pain or uncertain origin
- ____ 56. History of head injury or family history of violence/ explosiveness
- ____ 57. Dark thoughts, may be homicidal or suicidal
- ____ 58. Periods of forgetfulness or memory problems
- ____ Total number of questions with a score of 3 or 4 for questions 47- 58 (TL)

- ____ 59. Trouble staying focused
- ____ 60. Spaciness or feeling like you're in a fog
- ____ 61. Overwhelmed by tasks of daily living
- ____ 62. Feels tired, sluggish, or slow moving
- ____ 63. Procrastination, failure to finish things
- ____ 64. Chronic boredom
- ____ 65. Loses things
- ____ 66. Easily distracted
- ____ 67. Forgetful
- ____ 68. Poor planning skills
- ____ 69. Difficulty expressing feelings
- ____ 70. Difficulty expressing empathy for others
- ____ Total number of questions with a score of 3 or 4 for questions 59-70 (AD)

INTAKE PACKET
MODIFIED HCL-32 QUESTIONNAIRE

Please try to remember a period when you were in a “high” state. How did you feel then? Please check these statements even if you do not feel that way currently. Please put a check mark by each that have applied in the past or now.

	Description	
1	I need less sleep	<input type="checkbox"/>
2	I feel more energetic and more active	<input type="checkbox"/>
3	I am more self-confident	<input type="checkbox"/>
4	I enjoy my work more	<input type="checkbox"/>
5	I am more sociable (make more phone calls, go out more)	<input type="checkbox"/>
6	I want to travel and/or do travel more	<input type="checkbox"/>
7	I tend to drive faster or take more risks when driving	<input type="checkbox"/>
8	I spend more money/too much money	<input type="checkbox"/>
9	I take more risks in my daily life (in my work and/or other activities)	<input type="checkbox"/>
10	I am physically more active (sport etc.)	<input type="checkbox"/>
11	I plan more activities or projects.	<input type="checkbox"/>
12	I have more ideas, I am more creative	<input type="checkbox"/>
13	I am less shy or inhibited	<input type="checkbox"/>
14	I wear more colorful and more extravagant clothes/make-up	<input type="checkbox"/>
15	I want to meet or actually do meet more people	<input type="checkbox"/>
16	I am more interested in sex, and/or have increased sexual desire	<input type="checkbox"/>
17	I am more flirtatious and/or am more sexually active	<input type="checkbox"/>
18	I talk more	<input type="checkbox"/>
19	I think faster	<input type="checkbox"/>
20	I make more jokes or puns when I am talking	<input type="checkbox"/>
21	I am more easily distracted	<input type="checkbox"/>
22	I engage in lots of new things	<input type="checkbox"/>
23	My thoughts jump from topic to topic	<input type="checkbox"/>
24	I do things more quickly and/or more easily	<input type="checkbox"/>
25	I am more impatient and/or get irritable more easily	<input type="checkbox"/>
26	I can be exhausting or irritating for others	<input type="checkbox"/>
27	I get into more quarrels	<input type="checkbox"/>
28	My mood is higher, more optimistic	<input type="checkbox"/>
29	I drink more coffee	<input type="checkbox"/>
30	I smoke more cigarettes	<input type="checkbox"/>
31	I drink more alcohol	<input type="checkbox"/>
32	I take more drugs (sedatives, anti-anxiety pills, stimulants)	<input type="checkbox"/>