Gapp Counseling Services, LLC

Intake Form: *Please fill out all information you believe would be helpful for your child's treatment. Draw a line thru sections that do not apply. Please be as thorough as you can.* ***Thank you, Deb Gapp***

Gapp Counseling Services (GCS) will not discriminate based on race, color, creed, national origin, ancestry, citizenship, gender, sexual orientation, religion, age, or disability.

Date: _____/_____/_____ **File#**: _____
(for GCS use only)

Name: _____ _____ _____
First Middle Last

Age:_____

Date of birth: _____/_____/_____

Place of birth: _____

Gender: _____ Male _____ Female

Race/Ethnic Origin: **(Check one)**

☐ **White/Caucasian** ☐ **Asian/Asian American** ☐ **Pacific Islander** ☐ **African American/ Black**
☐ **Hispanic/Latino** ☐ **Other (please specify)** _____
☐ **Native American/ American Indian** ☐ **Tribal Member (Name of Tribe)**_____

Highest-grade level completed:

Address: _____
Street City State

_____
Zip Code County

Home Phone: _____ **E-mail address:** _____

Work Phone: _____ **Cell Phone:** _____

How may GCS contact you?

❒ Home phone ❒ Work phone ❒ Cell phone ❒ Mail ❒ E-mail ❒ Fax

In case of psychological or medical emergency, whom should we contact?

Contact Name: _____ Relationship: _____

Phone: _____City/State: _____

Reason for coming to Gapp Counseling Services
Please summarize the concerns that made you decide to bring your child to Gapp Counseling Services:

_____

_____

Since approximately what date has your child been having these issues?_____
How did you hear about Gapp Counseling Services? _____

Please answer questions in this intake packet on your child's behalf:

History of Mental Health Services

Have you had a psychological assessment in the past? ❒ Yes ❒ No

Are you currently receiving services from a psychiatrist, psychologist, counselor, chemical dependency professional, social worker, pastor, or other mental health practitioner for personal or mental health concerns? ❒ Yes ❒ No

Please indicate all the services you have participated in (currently or in the past) for your own and/or someone else's mental health concerns and/ or alcohol and drug use:

Age	Type of Treatment	Name And City/State Location Of Provider	Length Of Time You Received Services	Dates of Service
	Individual or group counseling			
	Psychological Evaluations			
	Alcohol or other Drug Assessments			
	Education or diversion programs for alcohol or other drug use (i.e. DUI classes)			
	Inpatient or Intensive Outpatient Treatment for substance abuse			
	Psychiatric service with a psychiatrist (i.e. medication management)			
	Psychiatric hospitalization			
	Self-help or support groups			

Indicate your (child's) level of concern on all situations that apply. Please check the corresponding box.	**NO CONCERN**	**LITTLE CONCERN**	**MODERATE CONCERN**	**EXTREME CONCERN**
1. Insomnia (problems falling or staying sleep, waking early)				
2. Nightmares				
3. Death of someone significant in my life				
4. Feeling sad, anxious, empty, and crying for no reason				
5. Thought or worries that keep racing around in my head				
6. Fatigue or decreased energy				
7. Think and speak more slowly than normal				
8. Have trouble concentrating, remembering, and making decisions				
9. Lost interest in things I once enjoyed				
10. Preoccupied with death and/or suicide				
11. Feeling helpless, guilty, or worthless				
12. Hopelessness or pessimistic feelings				
13. Loss of pleasure in usual activities				
14. Irritability				
15. Persistent thoughts of death				
16. Trembling, restlessness, rapid heartbeat				
17. Difficulty paying attention				
18. More active than normal, and tend to act without thinking				
19. Difficulty with listening and speaking				
20. Difficulty with reading, writing and spelling				
21. Difficulty doing math calculations				
22. Extreme distractibility				
23. Significant risk-taking				
24. Increased energy, activity, rapid talking & thinking, agitation				
25. Decreased need for sleep without fatigue				
26. Unrealistic belief in one's own abilities				
27. Can't accept no for an answer				
28. Excessive anger				
29. Trouble with major relationship				
30. Physically hurting siblings				
31. Feel overwhelmed by life				
32. Difficulty managing disappointment				
33. Bothered by thoughts of insanity				

Indicate all of the behaviors that apply to you (your child). Please check the corresponding box.	**NO CONCERN**	**LITTLE CONCERN**	**MODERATE CONCERN**	**EXTREME CONCERN**
34. Thoughts of killing myself				
35. Thoughts of self harm/cutting myself				
36. Hearing voices no one else can hear or see objects or things no one else can see				
37. Nightmares or flashbacks because of a traumatic/terrible event. For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, or being shot or stabbed				
39. Experience any strong feelings? For example, strong concern about heights, animals, dirt, attending social events, being in a crowd, being alone, being in places where it might be hard to escape or get help				
40. Experienced emotional problems due to sexual interests, activities, or partners				
41. Aggressive urges or impulses that I do not like having				
42. Slow in getting acquainted with people				
43. Not knowing how to study effectively				
44. Worried about a member of my family				
45. Hard to study in living quarters				
46. Not mixing well with the opposite sex				
47. Trouble in keeping a conversation going				
48. Slow in reading				
49. Unable to discuss certain problems at home				
50. Can't forget some mistakes I've made				
51. Getting into trouble with authorities				
52. Wondering if I'll find a suitable mate				
53. Being ill at ease with other people				
54. Doubting the wisdom of my vocational choice				
55. Being criticized by my parents				
56. Not knowing what I really want				
57. Thinking too much about sex matters				
58. Wanting more worthwhile discussions with people				
59. Forced to take courses I don't like				
60. Clash of opinions between me and my parents				
61. Wanting more chance of self-expression				

Indicate all of the behaviors that apply to you (your child). Please check the corresponding box.	NO CONCERN	LITTLE CONCERN	MODERATE CONCERN	EXTREME CONCERN
62. Concerns about my use of tobacco, alcohol, or drugs				
63. Concerns about other's use of tobacco, alcohol or drugs				
64. Wanting love and affection				
65. Being left out of things				
66. Needing to know my vocational abilities				
67. Confused in some of my religious beliefs				
68. Afraid to speak up in class discussions				
69. Not reaching the goals I've set for myself				
70. Too little social life				
71. Purpose in going to college not clear				
72. Disliking financial dependence on others				
73. Feelings of being "pushed around"				
74. Speaking or acting without thinking				
75. Finding it hard to talk about my troubles				
76. Wanting a more pleasing personality				
77. Fearing failure in college				
78. Financial problems				
79. Being timid or shy				
80. Not knowing where I belong in the world				
81. Lacking self-control				
82. Not being the kind of person I should be				
83. Family problems				

Have you ever thought of suicide? ❒ Yes ❒ No **Have you ever attempted suicide?** ❒ Yes ❒ No

If yes, number of times_____ Age ____Were alcohol and/ or drugs and /or medications involved? ❒ Yes ❒ No

Please explain the circumstances:

_____

_____

My current level of suicidal thought is (circle a number):

1 2 3 4 5 6 7 8 9 10

No risk moderate suicidal thoughts severe risk

Has a family member/friend/significant other attempted or committed suicide? ❒ Yes ❒ No

If yes, please explain the circumstances**:** _____

Have you had aggressive thoughts of hurting others in the past? ❒ Yes ❒ No

If yes please explain**:**_____

_____

My current level of aggressive thoughts of hurting others is (circle a number):

1 2 3 4 5 6 7 8 9 10
No risk some aggressive thoughts severe risk

MEDICAL/PHYSICAL INFORMATION

Do you consider your health to be: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Are you currently pregnant? ❒ Yes ❒ No ❒ Don't know

Past Pregnancies? ❒ Yes ❒ No

Your current weight _____ **Your current height** _____

Are you currently under the care of a health care provider such as a physician, psychiatrist, chiropractor, or other health practitioner? ❒ Yes ❒No

Where (or with whom): _____

Purpose: _____

Do you have any physical disabilities? ❒ Yes ❒ No If yes, please specify:_____

Have you had any significant illnesses or injuries now or in the past? ❒ Yes ❒ No

Age of illness of injury Type of illness of injury

_____

_____

_____ _____

Are you currently taking any prescribed medications for medical conditions or psychotropic medications for mental health concerns? ❒ Yes ❒ No

Name of medication and why do you take it: Dosage:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take your current medications as prescribed? …… ❒ Yes ❒ No
Do you take outdated or previously prescribed medications? …… ❒ Yes ❒ No

Are you covered under a health insurance plan? ❒ Yes ❒ No

If yes, please indicate name of health insurance provider: _____

Please indicate which of the following you have now or have had in the past:

	Never	One time	Occasional	Recurrent		Never	One Time	Occasional	Recurrent
Headaches					Malnutrition				
Earaches					Hepatitis				
Respiratory Problems					Seizures				
STDs (Sexually Transmitted Diseases)					Hypoglycemia				
Cirrhosis or other liver problems					Diabetes				

Do you have any allergies? ❒ Yes ❒ No

If yes, to what are you allergic?

❒ Milk/Dairy ❒ Soy ❒ Latex ❒ Pollen ❒ Dog/cat dander
❒ Wheat ❒ Shellfish ❒ Mold ❒ Airborne ❒ Medication
❒ Corn ❒ Nuts/Peanuts ❒ Dust ❒ Other _____

Have you experienced weight fluctuations in the past year? ❒ Yes ❒ No

In regards to food or to control your weight, have you ever:

❒ stopped eating/hardly ate at all ❒ binged
❒ purged (vomit) ❒ dieted
❒ used laxatives ❒ thought about food frequently
❒ exercised excessively ❒ been on diet plans (i.e. Weight Watchers, Nutri-System)
❒ loss of appetite ❒ used herbal or other weight control products to control weight (i.e. Hydroxy Cut)

TB Risk Assessment

Have you experienced any of the following in the last 3 months?

1. An **unexplained** cough lasting 2-3 weeks that produces sputum such as: ❒ Yes ❒ No
   (Green, Yellow, White-Creamy, Clear, Blood-tinged, Dark red blood, Bright red blood)
2. **Unexplained** night sweats ❒ Yes ❒ No
3. **Unexplained** fevers ❒ Yes ❒ No
4. **Unexplained** weight loss ❒ Yes ❒ No

EDUCATIONAL

Please list all of your educational experiences.

Name of SCHOOL	**Last grade completed**	How were your grades? (Poor, Fair, Good, or Excellent)	Did you have any behavior related problems in school?	Did you have any learning or academic problems?
Elementary School				
Middle School				

Do you have a learning disability? ❒ Yes ❒ No ❒ Think I do, but never diagnosed

If yes, what types? ❒ Reading ❒ Writing ❒ Math ❒ Attention ❒ Other _____

Did/has your use of alcohol/other drugs kept you from going to school, or negatively affected your academic performance?

❒ Yes ❒ No If yes, how many times _____ If yes, please explain: _____

Have personal or mental health concerns or the medications prescribed to treat them, kept you from going to school, or negatively affected your academic performance? ❒ Yes ❒ No

If yes, how many times? _____ If yes, please explain: _____

LEGAL

Have you ever been arrested or had police intervention for your behavior? ❒ Yes ❒ No

Were these charges related to personal or mental health concerns? ❒ Yes ❒ No

Please explain: _____

_____

Date (dd/mm/yy): Offense:

1. _____ _____
2. _____ _____
3. _____ _____

SOCIAL

Number in household: _____

Do you live: ❒ with a foster family/legal guardian ❒ with parent(s) ❒ with unrelated person(s) ❒ with relative(s)

With whom do you usually talk over your problems or plans?

_____

_____

Do you consider yourself to have: ❒ many, ❒ few, or ❒ very few acquaintances?

_____

In what activities, community, or civic organizations do you participate?

_____

What kind of hobbies, interests, social activities, or activities do you like to do?

_____

Do your personal concerns have a negative effect on your relationships or your social life? ❒ Yes ❒ No
If yes, please describe:_____

_____

FAMILY INFORMATION

Please provide the following information regarding your family, i.e., you as the parents, step-parents, and info re: your child's brothers, sisters, step-siblings, etc.

Relationship	Name	Age	Occupation	Education	Single	Married	Divorced	Widowed	Deceased

Check all that describe your immediate family/family of origin/home environment:

❒Flexible ❒Rigid ❒Relaxed atmosphere ❒Tense atmosphere

❒Open system ❒Closed system ❒Fun, joy, playful ❒Grim, serious

❒Individuality encouraged ❒Conformity encouraged ❒Intimacy sought ❒Intimacy avoided

❒Feelings expressed ❒Feelings constricted ❒Autocratic decision-making ❒Democratic decision-making

❒Focus on behaviors and performance ❒Respected

❒Balance of focus on feelings, behavior and performance

If there is a family history of mental health problems and/or a significant alcohol, drug or gambling problem, abuse, or addiction, please check all that apply:

Family Member ➔ / Condition🡻	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Child's Mother	Child's Father	Any Bio-Brother	Any Bio-Sister	Any Bio-Aunts	Any Bio-Uncles
Anger										
Anxiety										
Depression										
Major Depression										
Sleep Problems										
Thought problems										
Schizophrenia										
Bipolar Disorder										
Self-harm										
Eating Disorders										
Physical Abuse										
Sexual Abuse										
Emotional Abuse										
Domestic Violence										
Gambling Problems										
Alcohol Problems										
Drug Problems										

Were any of the above conditions treated with medications, counseling, psychiatric services, hospitalization, substance abuse treatment (others), or not at all? Please explain:

SPIRITUAL BELIEFS

Describe your spiritual beliefs:

_____

_____

To what, if any, church, religious organization, movement, or group do you belong?

_____

To what degree do you participate in your spiritual beliefs? _____

Request for Services /

Statement of Confidentiality

I, _____ am applying for diagnostic and/or
(Parent's name)

treatment, or counseling services at the Gapp Counseling Services (GCS) for my child,

_____, _____.
(Child's name) *(Date of Birth)*

I understand that all information revealed in counseling will be held in the strictest confidence, except when authorized by me in writing or in situations outlined below:

1. Client consents to such disclosure;
2. A Court Order mandates disclosure;
3. In accordance with statutes mandating reporting of child abuse;
4. The disclosure is made to medical, psychological, or other emergency personnel in a medical emergency or to qualified personnel for research, psychological audit, or program evaluation
5. Submission of claims to insurance or Medicaid.

_____ _____
Parentt Signature *Date*

HIPAA Acknowledgement

By signing below, I am stating that I have either been provided with a copy of the Notice of Privacy Practices and/or have had the opportunity to read the Notice of Privacy Practices.

_____ _____
Parent Signature *Date*

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