Beloit Health System
COUNSELING CARE CENTER
INITIAL INTAKE ASSESSMENT

Legal Name_____ Medical Record Number _____

Preferred Name _____ Personal Pronouns _____

Therapist _____ Today's Date (Intake) _____

Parent/Legal Guardian: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other _____

Briefly describe the problem for which you are seeking to have counseling for? _____

_____

_____

What would you like to see happen as a result of counseling? _____

_____

_____

Please check all that apply:

☐ Abuse (perpetrator)	☐ Confused	☐ Hyperactivity	☐ Restricted Eating
☐ Abuse (victim)	☐ Delusions	☐ Impaired concentration	☐ Sleep disturbance (decrease)
☐ Aggression	☐ Depressed mood	☐ Inability to maintain normal weight	☐ Sleep disturbance (increase)
☐ Agitation	☐ Distorted body image	☐ Loss of energy	☐ Suicidal
☐ Amnesia	☐ Emaciation	☐ Manic symptoms	☐ Thought disturbance
☐ Anxiety	☐ Excessive exercise	☐ Mood instability	☐ Thoughts to harm others
☐ Appetite decrease	☐ Excessive fear	☐ Mood swings	☐ Trauma
☐ Appetite increase	☐ Excessive use of laxatives or diuretics	☐ Neglect (perpetrator)	☐ Withdrawal symptoms
☐ Assaultive	☐ Forced vomiting	☐ Neglect (victim)	☐ Worthlessness/Guilt
☐ Attention deficit	☐ Hallucinations	☐ Obsessive compulsive behavior	☐ Anger
☐ Bereaved	☐ Hoarding	☐ Poor impulse control	☐ Other:
☐ Binge eating	☐ Homicidal	☐ Preoccupation with weight	☐ Other:
☐ Conduct/Disruptive behavior	☐ Hopelessness	☐ Relationship problems	

Name: _____ Date: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge.	☐ (0)	☐ (1)	☐ (2)	☐ (3)
2. Note being able to stop or control worrying.	☐ (0)	☐ (1)	☐ (2)	☐ (3)
3. Worrying too much about different things.	☐ (0)	☐ (1)	☐ (2)	☐ (3)
4. Trouble relaxing.	☐ (0)	☐ (1)	☐ (2)	☐ (3)
5. Being so restless that it's hard to sit still.	☐ (0)	☐ (1)	☐ (2)	☐ (3)
6. Becoming easily annoyed or irritable.	☐ (0)	☐ (1)	☐ (2)	☐ (3)
7. Feeling afraid as if something awful might happen.	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Column Scores:				
Total Score:				
If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Feeling down, depressed, or hopeless

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Trouble falling or staying asleep, or sleeping too much

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Feeling tired or having little energy

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Poor appetite or overeating

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Feeling bad about yourself – or that you are a failure of have let yourself or family down

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Trouble concentrating on things, such as reading he newspaper or watching television

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Moving or speaking so slowly that other people could have noticed? Or fidgety or restless that you have been moving a lot more than usual

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Thoughts that you would be better off dead, or thoughts of hurting yourself in some way

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ (0) Not at all ☐ (3) More than half the days
☐ (1) Several days ☐ (4) Nearly every day

Total Score:	

Columbia-Suicide Severity Rating Scale

Name: _____ Date: _____

Please place a check mark in the box for questions 1 and 2	Past Month	
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Yes ☐	No ☐
2. Have you actually had any thoughts of killing yourself? If YES, answer all questions 3, 4, 5, and 6. If NO, skip directly to question 6.	Yes ☐	No ☐
3. Have you thought about how you might do this? *(For example, "I thought about taking an overdose but I never worked out details about when, where, and how I would do that and I would never act on these thoughts.")*	Yes ☐	No ☐
4. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them? *(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")*	Yes ☐	No ☐
5. Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan? *(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")*	Yes ☐	No ☐
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *(For example: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note; etc.)*	Yes ☐	No ☐
If YES, did this occur in the past 3 months?	Yes ☐	No ☐
Totals:		