Kish*Health* Counseling Services
Intake Information

Full Name: _____ **Birth Date:** _____

Referred By: _____ **Phone:** _____

Reason for visit (brief description):

_____

_____

List All Members Living In Household (including non custodial visiting children):

Full Name	Age	Grade (if applicable)	Concerns (?)

Names of Current Physicians:

Full Name	Type of Physician	Location of Practice	Date Last Seen

Please List Current Medications:

Name of Medication	Name of Prescribing Physician	Dosage	Reason for Taking

SECTION I

PLEASE MARK AN "X" IN THE APPROPRIATE BOX FOR EACH QUESTION	YES	NO
In the past two weeks:		
• Have you been consistently depressed/down most of the day, nearly every day?		
• Have you been less interested in most things or less able to enjoy the things you used to enjoy?		
• Has you appetite decreased or increased nearly every day?		
• Has your weight decreased or increased without trying intentionally?		
• Have you had trouble sleeping nearly every night (falling asleep, waking up, and sleeping excessively)?		
• Have you been talking or moving more slowly than normal?		
• Have you been more fidgety, restless, or having trouble sitting still almost every day?		
• Have you been feeling tired or without energy almost every day?		
• Have you been feeling worthless or guilty almost every day?		
• Have you been having difficulty concentrating or making decisions almost every day?		
• Have you been considering hurting yourself, feel suicidal, or wish that you were dead?		

SECTION II

PLEASE MARK AN "X" IN THE APPROPRIATE BOX FOR EACH QUESTION	YES	NO
In the past month, were you fearful of or embarrassed by being watched or being the focus of attention, or fearful or being humiliated? This includes things like speaking in public, eating in public along or with others, writing while someone watches, or being in social situations.		
Is the above fearful, excessive or unreasonable?		
Do you fear these situations so much that you avoid them or suffer through them?		
Does this fear disrupt your normal work or social functioning or cause you significant distress?		

SECTION III

PLEASE MARK AN "X" IN THE APPROPRIATE BOX FOR EACH QUESTION	YES	NO
In the past 12 months:		
• Have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?		
• Did you need to drink more in order to get the same effect that you got when you first started drinking?		
• When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms check yes if either is true.		
• During the times when you drank alcohol, did you end up drinking more than you planned when you started?		
• Have you tried to reduce or stop drinking alcohol but failed?		
• On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effect of alcohol?		
• Did you spend less time working, enjoying hobbies, or being with others because of your drinking?		
• Have you continued to drink even though you knew that it caused you problems?		

SECTION IV

PLEASE MARK AN "X" IN THE APPROPRIATE BOX FOR EACH QUESTION	YES	NO
Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable, or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either please check "YES")		
At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?		

SECTION V (only answer if you answered yes in Section IV)

PLEASE MARK AN "X" IN THE APPROPRIATE BOX FOR EACH QUESTION	YES	NO
During the worst spell you can remember:		
• Did you have skipping, racing, or pounding of your heart?		
• Did you have sweating or clammy hands?		
• Were you trembling or shaking?		
• Did you have shortness of breath or difficulty breathing?		
• Did you have a choking sensation or a lump in your throat?		
• Did you have chest pain, pressure or discomfort?		
• Did you have nausea, stomach problems or sudden diarrhea?		
• Did you feel dizzy, unsteady, lightheaded or faint?		
• Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?		
• Did you fear that you were losing control or going crazy?		
• Did you fear you were dying?		
• Did you have tingling or numbness in parts of your body?		
• Did you have hot flushes or chills?		
In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack?		

SECTION VI

PLEASE PLACE AN "X' NEXT TO ANY CONCERN YOU ARE EXPERIENCING					
Phobias		Obsessions/Compulsions		Elevated Mood	
Irritability		Social Isolation		Excessive Spending	
Financial Problems		Self-Mutilation		Hyperactivity	
Excessive Gambling		Bingeing/Purging		Separation/Divorce	
Care Giving Concerns		Grief/Loss		Excessive Internet Use	
Legal Problems		Relationship Conflict		Domestic Violence	

SECTION VII

FOR CHILDREN/ADOLESCENTS ONLY					
Failing Grades		School Problems		Family Conflict	
Parent/Child Conflict		Parents Divorcing		Parents Separating	
Dating Conflict		Peer/Friend Conflict		Adjustment/New School	
School Stress		Learning Problems		ADHD	
General Depression		General Anxiety		General Stress	
Other (Please specify):					