

**La Luna Center  
Intake Questionnaire**

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**C O N F I D E N T I A L**

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# Client Information

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ eMail Address \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ Is it ok to leave a phone message? (please circle) No Yes  
Cell (\_\_\_\_\_) \_\_\_\_\_ Is it ok to leave a phone message? (please circle) No Yes

Please indicate other professionals, if any with whom you are currently working.

Name of Individual Therapist \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Other Professional \_\_\_\_\_ Phone # \_\_\_\_\_

## Please circle appropriate categories:

Citizenship: United States Other \_\_\_\_\_

Preferred Language: English Other \_\_\_\_\_

## School Information: (if applicable)

School Name: \_\_\_\_\_

Class: Freshman Sophomore Junior Senior Graduate Other: \_\_\_\_\_

Highest Level of Education: None High School/GED Associates Bachelors Graduate

## Employment Information: (if applicable)

Employment: Full time Part time # of Hours/week \_\_\_\_\_

Employer: \_\_\_\_\_

Residence: With Family With Spouse/Partner Alone Roommates Other: \_\_\_\_\_

Referred by: Self Other (Name) \_\_\_\_\_

## Health Insurance Information

Insurance Company Name: \_\_\_\_\_ Member ID number: \_\_\_\_\_

Phone number for Mental Health Benefits (usually on the back of the card): \_\_\_\_\_

## Financial Information

Financially Responsible Person:  Self  Other (please specify) \_\_\_\_\_ Phone # \_\_\_\_\_

## Emergency Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

If a minor (under 18), who has legal custody or guardian status: \_\_\_\_\_

## INTAKE QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background, in order to assist in the development of your treatment plan. Please answer all questions as fully and accurately as possible. Please note that this material is confidential and the results of this questionnaire will be released to no one outside of La Luna Center without your written permission.

**Please describe yourself as fully as you feel comfortable:**

**How much reluctance to you have about coming in to La Luna Center today?** Please circle one:

No reluctance at all    Very little reluctance    Some reluctance    Quite a bit of reluctance    Strong reluctance

**If more than one applies to you, please check all that apply:**

<i>Gender</i>	<i>Relationship Status</i>	<i>Sexual Orientation</i>	<i>Ethnicity/Race</i>
<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Bi-Sexual	<input type="checkbox"/> African-American
<input type="checkbox"/> Female	<input type="checkbox"/> Married or Partnered	<input type="checkbox"/> Queer	<input type="checkbox"/> Arab American
<input type="checkbox"/> Transgender	<input type="checkbox"/> Separated	<input type="checkbox"/> Gay or Lesbian	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> MTF	<input type="checkbox"/> Divorced	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> White, Non-Hispanic
<input type="checkbox"/> FTM	<input type="checkbox"/> Widowed	<input type="checkbox"/> Questioning	<input type="checkbox"/> Chicano, Latino, Hispanic
<input type="checkbox"/> Intersex	<input type="checkbox"/> Other _____		<input type="checkbox"/> Native or Alaskan Native
			<input type="checkbox"/> Other _____

**Culture you most identify with:**

**Religious affiliation/ Spirituality:**

**Do you identify as having a disability?**    No    Yes (please specify)

In addition to your eating concerns, please check all issues that currently concern you:

- |  |  |
|--|--|
| <input type="checkbox"/> Depression                                | <input type="checkbox"/> Working Through a Traumatic Event(s)  |
| <input type="checkbox"/> Bipolar (Mania -Depression)               | <input type="checkbox"/> Clarification of Own Values   |
| <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> Sexual Health Issues  |
| <input type="checkbox"/> Alcohol Use                               | <input type="checkbox"/> Understanding Own Sexuality   |
| <input type="checkbox"/> Substance Use                             | <input type="checkbox"/> coming-out <input type="checkbox"/> sexual orientation <input type="checkbox"/> gender identity |
| <input type="checkbox"/> Attention Deficit Disorder                | <input type="checkbox"/> Adjusting to School/Work  |
| <input type="checkbox"/> Self-understanding                        | <input type="checkbox"/> Improved Relationships with:  |
| <input type="checkbox"/> Self-acceptance                           | <input type="checkbox"/> Friends <input type="checkbox"/> Partner <input type="checkbox"/> Family                        |
| <input type="checkbox"/> Self-care (hygiene, taking time for self) | <input type="checkbox"/> Issues of Racial/Ethnic Identity  |
| <input type="checkbox"/> Good Decision Making                      | <input type="checkbox"/> Understanding My Impact on Others   |
| <input type="checkbox"/> Assertiveness                             | <input type="checkbox"/> Decreasing Own Suicidal Thoughts  |
| <input type="checkbox"/> Stress Management                         | <input type="checkbox"/> Eliminating/Reducing Unhealthy Behavior   |
| <input type="checkbox"/> Grief                                     | <input type="checkbox"/> Academic/Work Problems  |

Please check all the following symptoms that you have experienced:

= Recent (within the last month)

= Past (one month ago or longer)

- |  |  |
|--|--|
| <input type="checkbox"/> <input type="radio"/> change in appetite                          | <input type="checkbox"/> <input type="radio"/> feelings of restlessness                        |
| <input type="checkbox"/> <input type="radio"/> significant weight gain/loss                | <input type="checkbox"/> <input type="radio"/> trembling or shaking                            |
| <input type="checkbox"/> <input type="radio"/> change in mood                              | <input type="checkbox"/> <input type="radio"/> accelerated heart rate                          |
| <input type="checkbox"/> <input type="radio"/> irritability                                | <input type="checkbox"/> <input type="radio"/> shortness of breath                             |
| <input type="checkbox"/> <input type="radio"/> feelings of worthlessness                   | <input type="checkbox"/> <input type="radio"/> sweating  |
| <input type="checkbox"/> <input type="radio"/> changes in sleeping patterns                | <input type="checkbox"/> <input type="radio"/> chest pain                                      |
| <input type="checkbox"/> <input type="radio"/> loss of energy                              | <input type="checkbox"/> <input type="radio"/> feelings of choking                             |
| <input type="checkbox"/> <input type="radio"/> loss of interest in activities              | <input type="checkbox"/> <input type="radio"/> nausea  |
| <input type="checkbox"/> <input type="radio"/> loss or decrease in sexual interest         | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of death                     |
| <input type="checkbox"/> <input type="radio"/> increase of energy                          | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of wanting to commit suicide |
| <input type="checkbox"/> <input type="radio"/> difficulty concentrating                    | <input type="checkbox"/> <input type="radio"/> recurrent thoughts of harming others            |
| <input type="checkbox"/> <input type="radio"/> nightmares                                  | <input type="checkbox"/> <input type="radio"/> cutting or burning myself                       |
| <input type="checkbox"/> <input type="radio"/> substance abuse (alcohol or drugs)          | <input type="checkbox"/> <input type="radio"/> seeing things that others do not                |
| <input type="checkbox"/> <input type="radio"/> problems with attention, motivation, memory | <input type="checkbox"/> <input type="radio"/> hearing voices that others do not               |
| <input type="checkbox"/> <input type="radio"/> recurrent and excessive anxiety or worry    | <input type="checkbox"/> <input type="radio"/> paranoid thoughts                               |

**HISTORY OF EATING /BODY IMAGE CONCERNS:**

Please estimate the severity of your disordered eating (check):

- Mildly upsetting   Moderately severe   Very severe   Incapacitating

When did you start to struggle with eating?

Give a brief account of the history and development of this struggle:

Describe a typical current day in your relationship with food (behaviors and frequency):

What do you think is presently causing your disordered eating?

What strengths do you bring to this problem which will assist you in overcoming it?

How would your life be different if you didn't have an eating disorder?

What are your short and long term goals for treatment?

**DESCRIBE YOUR CURRENT FUNCTIONING:**

<i>Currently, I am able to...</i>	n/a	Never	Rarely	Sometimes	Frequently	Always
attend work/classes						
concentrate on duties /tasks/assignments						
maintain employment						
maintain satisfying relationship w/ significant other						
maintain satisfying relationships w/ family members						
initiate & maintain satisfying social relationships w/ peers						
take care of my self & participate in social/recreational activities						
decide on plans for future						
demonstrate adequate coping skills, esp under increased stress						
seek assistance when stress and problems are not manageable						
decrease substance abuse and/or other high-risk behaviors						

Are you thinking about leaving your job or school?   No   Yes

Are you at risk for being of being fired from your job or expelled from school? No Yes

Are you experiencing any financial stressors? No Yes (describe):

Describe your work and /or academic performance:

Describe your support systems (friends, family, spiritual or cultural groups, etc.):

Describe your past and current levels of exercise or physical activity:

Describe your current interests, hobbies and activities:

**PERTINENT PERSONAL/FAMILY HISTORY:** (Please fill in information about yourself and your family members)

	<i>Biological?</i>	<i>Age</i>	<i>Occupation</i>	<i>Mental Health Concerns</i>	<i>Physical Health Concerns</i>	<i>Medical Concerns</i>
<i>You</i>	n/a					
<i>Parent</i>	Y N					
<i>Parent</i>	Y N					
<i>Parent</i>	Y N					
<i>Parent</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Brother/Sister</i>	Y N					
<i>Child M F</i>	Y N					
<i>Child M F</i>	Y N					
<i>Child M F</i>	Y N					
<i>Spouse/Partner</i>	n/a					
<i>Others</i>						

Are your parents married / separated / divorced / remarried?

If divorced, how old were you at that time?

Describe your father's personality and his attitude towards you (Past and present)

Describe your mother's personality and her attitude towards you (Past and present):

Describe the home atmosphere in which you grew up. Was it a tense or relaxed environment? Orderly or chaotic? Noisy or quiet? Did people speak openly about their problems and feelings?

Describe your relationship(s) with your sibling(s):

Describe your relationship(s) with your child/children:

Describe your relationship(s) with your partner/spouse:

Have you lost any direct family members? No Yes – Please list:

Do members of your extended family (grandparents, aunts, uncles, etc.) have a history of mental health concerns (depression, anxiety, eating disorders etc.)? No Yes – Please list:

Is there a history of alcoholism in your extended family? No Yes – Please list:

## **MEDICAL HISTORY**

\*Date of your most recent Physical Exam: \_\_\_\_\_

\*Are you currently in physical pain? No Yes (describe):

Please list current medications (including dosage and frequency):

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<i>Have you had...</i>	<u>Recently</u> <i>(if yes, describe)</i>	<u>Past</u> <i>(if yes, describe)</i>
a head injury?	N Y	N Y
a seizure?	N Y	N Y
loss of consciousness?	N Y	N Y
*fainting?	N Y	N Y
*cardiac conditions?	N Y	N Y
*vomiting blood?	N Y	N Y
*laxative abuse?	N Y	N Y
*abnormal bloodwork?	N Y	N Y
*diabetes?	N Y	N Y
known allergies?	N Y	N Y
significant injuries or illness?	N Y	N Y
hospitalization for a medical condition?	N Y	N Y

### PREVIOUS MENTAL HEALTH TREATMENT

Age	With Whom	How Long	Focus of Treatment	Helpful?	List Medications
				N Y	
				N Y	
				N Y	
				N Y	

Have you ever been hospitalized for mental health treatment?    No    Yes    If yes, was it voluntary?    No    Yes

### SUICIDAL/HOMICIDAL/ASSAULTIVE THOUGHTS OR BEHAVIORS

<i>Have you ever had...</i>	<u>Current</u> <i>(if yes, describe)</i>	<u>Past</u> <i>(if yes, describe)</i>
***thoughts of hurting yourself?	N Y	N Y
***thoughts of suicide?	N Y	N Y
***a plan for suicide?	N Y	N Y
an attempted suicide?	N Y	N Y
thoughts of hurting someone else?	N Y	N Y
an incident of actually hurting someone else?	N Y	N Y

If yes to any \*\*\* questions above, what are some of the things or people that prevent you from self-harm?

**TRAUMA HISTORY**

Have you ever been a victim of a crime? No Yes

Physical (e.g., car accidents, assault, abuse, head trauma, witnessing violence)

Emotional (e.g., victim of crime, abuse, loss or death of relative / friend)

Sexual (e.g., sexual harassment, sexual assault)

**LEGAL HISTORY:** Have you ever been arrested or convicted of a legal violation? No Yes (describe)

Are you currently involved in legal proceedings? If yes, will that impact your treatment at La Luna Center?

**SEXUAL ACTIVITY:** Are you sexually active? No Yes

Do you use latex condoms or other safer sex techniques every time to prevent sexually transmitted diseases? No Yes

**SUBSTANCE USE HISTORY:** Please indicate your use of the following substances:

List	Current Use		Past Use	
	Frequency # of days of the week	Amount Per Day	Frequency # of days of the week	Amount of Use Per Day
Alcohol	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Drugs	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Marijuana	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Tobacco	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	
Caffeine	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

Any other addictive behaviors? (gambling, shopping, etc):

**Thank you for completing the intake questionnaire.**