

**La Luna Center
Intake Questionnaire**

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

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.

Date: _____ **NAME:** _____

SSN: _____ **DOB:** _____ **AGE:** _____

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 _____

School Information:

School Name: _____ **Major:** _____

Class: Freshman Sophomore Junior Senior 5th Year Graduate Transfer Student

School Status: Full time Part time Continuing Education

Employment Information:

Employment: Full time Part time # of Hours/week _____

Employer: _____

Residence: With Family Alone Roommates Dorm Off-Campus Other: _____

Referred by: Self Family Friend Doctor Counselor Advisor Administrator
Name/or Other _____

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>
___ Male	___ Single	___ Bi-Sexual	___ African-American
___ Female	___ Married or Partnered	___ Gay or Lesbian	___ Arab American
___ Transgender	___ Separated	___ Heterosexual	___ Asian or ___ Pacific Islander
___ MTF	___ Divorced	___ Questioning	___ Caucasian, European-American
___ FTM	___ Widowed		___ Chicano, Latino, Hispanic
___ Intersex	___ Other _____		___ Native or ___ Alaskan Native
			___ Other _____

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"/> Sexual Health Issues |
| <input type="checkbox"/> Bipolar (Manic -Depression) | <input type="checkbox"/> Understanding Own Sexuality |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> coming-out process |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> sexual orientation |
| <input type="checkbox"/> Substance Use | <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"/> Self-care (hygiene, taking time for self) | <input type="checkbox"/> Partner |
| <input type="checkbox"/> Good Decision Making | <input type="checkbox"/> Family |
| <input type="checkbox"/> Assertiveness | <input type="checkbox"/> Issues of Racial/Ethnic Identity |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Respecting Cultural Differences |
| <input type="checkbox"/> Clarification of Own Values | <input type="checkbox"/> Understanding My Impact on Others |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Decreasing Own Suicidal Thoughts |
| <input type="checkbox"/> Working Through a Traumatic Event(s) | <input type="checkbox"/> Eliminating/Reducing Unhealthy Behavior |
| <input type="checkbox"/> Other (specify): | <input type="checkbox"/> Academic/Work Problems |

Please check all the following symptoms that you have experienced:

- | | |
|--|--|
| <input type="checkbox"/> = Recent (within the last month) | <input type="radio"/> = 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 CONCERNS/BODY IMAGE CONCERNS:

State in your own words the nature of your disordered eating:

When did you start to struggle with eating?

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

Please estimate the severity of your disordered eating (check): ? Mildly upsetting ? Moderately severe
 ? Very severe ? Incapacitating

What do you think is presently causing your disordered eating?

Have you received other treatment for your eating concern? If so where, when & with whom?

If you *have* sought treatment previously, why do you think this other treatment was unsuccessful?

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?

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

Describe your work and /or academic performance:

Describe struggles you are having in your relationships (friendships / dating / partner)?

Describe your support systems (friends, family, spiritual or cultural groups, etc.): Are they in Boulder? No Yes

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

Current interests, hobbies and activities

How is most of your free time spent?

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>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 family members (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

<i>Have you had...</i>	<u>Recently</u> (if yes, describe)	<u>Past</u> (if yes, describe)
a head injury?	N Y	N Y
a seizure?	N Y	N Y
loss of consciousness?	N Y	N Y
significant injuries or illness?	N Y	N Y
medications prescribed?	N Y	N Y
known allergies to medications?	N Y	N Y
hospitalization for a medical condition?	N Y	N Y

List Current Medications (if different from above) _____

PREVIOUS MENTAL HEALTH TREATMENT (in addition to eating focused treatment previously listed)

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>	<i>Current (if yes, describe)</i>		<i>Past (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

TRAUMA HISTORY

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

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

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?

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	
	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	
	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	
	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	
Other	0 1 2 3 4 5 6 7		0 1 2 3 4 5 6 7	

Please describe anything else you would like to share that would help us understand you better and develop the best possible plan for your treatment:

Thank you for completing the intake questionnaire.