Advanced
Spine and Pain

Name of the Patient: _____ Date: _____

PSYCHOLOGICAL THERAPY / COUNSELING INTAKE FORM

- Are you **currently** receiving psychiatric services, professional counseling or psychotherapy elsewhere?
  □ No □ Yes, with (the therapist's name or where?)_____

- Have you **had previous** psychotherapy?
  □ No □ Yes, with (previous therapist's name or where?)_____

- Are you **currently** taking prescribed psychiatric medication (antidepressants or anti-anxiety meds)?
  □ No □ Yes

  If yes, please list: _____

  _____

  Prescribed by: _____

- Are you having any problems with your **sleep habits**? □ No □ Yes
  □ Sleeping too little □ Sleeping too much
  □ Disturbing dreams □ Poor quality sleep □ Other _____

- Are you having any difficulty with **appetite or eating habits**? □ No □ Yes
  □ Eating less □ Eating more □ Bingeing □ Restricting □ Other _____

- Have you experienced significant **weight change** in the last 2 months? □ Yes □ No

- Are you **smoking cigarettes** or using other tobacco products? □ No □ Yes □ How much? _____

- Do you regularly **use alcohol**? □ No □ Yes □ If so, how much? _____

- How often do you engage **recreational drug use**? □ No □ Yes □ If so, what kind/type? _____
  If so, how often? □ Daily □ Weekly □ Monthly □ Rarely □ Socially

- Have you recently experienced any significant life changes or stressors?

  If yes, please explain: _____

  _____

- Have you recently experienced any of the following?

Depressed mood	**□ Yes □ No**
Dramatic mood swings	**□ Yes □ No**
Rapid speech	**□ Yes □ No**
Anxiety	**□ Yes □ No**
Panic attacks	**□ Yes □ No**
Phobias	**□ Yes □ No**
Sleep disturbances	**□ Yes □ No**
Hallucinations	**□ Yes □ No**
Unexplained losses of time	**□ Yes □ No**
Unexplained memory lapses	**□ Yes □ No**
Alcohol/substance abuse	**□ Yes □ No**
Frequent body complaints	**□ Yes □ No**
Eating disorder	**□ Yes □ No**
Body image problems	**□ Yes □ No**
Repetitive thoughts (e.g. obsessions)	**□ Yes □ No**
Repetitive behaviors (e.g. frequent checking, hand washing	**□ Yes □ No**
Homicidal thoughts	**□ Yes □ No**
Suicidal Thoughts and/or attempts	**□ Yes □ No**

- What are your goals from psychotherapy/counseling?

_____

_____

_____

_____

_____

_____

_____

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

PHQ-9 (Depression Screening)	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless?	0	1	2	3
Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself – or that you are a failure of have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3
TOTAL				

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

□ **Not at all** □ **Somewhat difficult** □ **Very difficult** □ **Extremely difficult**

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

Generalized Anxiety Disorder Screening (GAD-7)	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge?	0	1	2	3
Not being able to stop or control worrying?	0	1	2	3
Worrying too much about different things?	0	1	2	3
Trouble relaxing?	0	1	2	3
Being so restless that it is hard to sit still?	0	1	2	3
Becoming easily annoyed or irritable?	0	1	2	3
Feeling afraid as if something awful might happen?	0	1	2	3
TOTAL				

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

□ **Not at all** □ **Somewhat difficult** □ **Very difficult** □ **Extremely difficult**

Name of the Patient: _____

Signature of the Patient: _____

Date: _____