Strategic Resolutions LLC

"BUILDING A BETTER YOU!"

Services for Individuals, children and families

419 Whalley Ave Suite 309, New Haven, CT 06511
Office: (203) 823-9150 or (203) 687-4127 Fax: 203-905-6809

Intake Information

Please complete the following questionnaire. This information will be discussed more thoroughly n session and used to determine goals for treatment.

Name: Date of Birth:

Address:

Telephone Number: Home: Work: Cell:

Can I leave a message at home? Work: Cell:

Can I reach you by email: If so what is your email?

Occupation:

Employer:

How satisfied are you with your job?

Ever Fired?

Employment goals?

Briefly describes your reason(s) for seeking help at this time:

What do you wish to accomplish through the process of therapy?

Approximately how many visits do you think it will take?

Marital/Relationship Status (check all that apply):

Married___ Separated____ Widowed____ Divorced___ Remarried___

Single___ Long term relationship____ Cohabitating___ Other____

Current partners name:

Partners occupation:
Length of relationship:
How satisfied are you with this relationship?
Any conflict with your partner or spouse?
Previous marriage:
Reason for Divorce:

Children? If so names and ages:

Problems with your children?

Father name: age: Occupation:
If Deceased: Age deceased Cause:

Mother Name: age: Occupation:
If Deceased: Age deceased Cause:

Siblings: (Name, Age,

Relationship with Siblings:

Form of discipline growing up:

Unresolved Issues:

Crisis or Abuse:

History of moving:

Been in trouble with the law?

Highest level of education:

Military service

Did you like school?

Special Interest?

Excelled In any subjects in school?

Medical History:

Current Health

Physician: Clinic:
Date of last exam: Current Medications:
Chronic illness/allergies/PMS
ER/overnight hosp./outpatient surgery:

Current Concerns regarding your health:

Problems with sleep, appetite:

Exercise:

Past history of medical concerns:

Family History of medical concerns:

Risk Indications
Chemical Use: fill in every blank using the following numbers to represent your use of these chemicals.

Scale: 1-Never 2-Experimental/rarely 3-Some/Occasionally 4- Monthly
5-Weekly 6-Daily 7- Once heavily, no longer

1 Coffee 1 Tea 1 Tobacco 1 Aspirin 1 Tranquilizers 1 Marijuana 1 Cocaine

1 Heroin 1 Alcohol 1 Sleep Medicines-Type:

1 Inhalants 1 Crank 1 Crystal

1 Opiates 1 Anti-Depressants-Type:

1 Narcotics 1 Crack 1 Ecstasy 1 Steroids 1

1 Other prescriptions drug-Type/Dose:

Psychiatric History:

Previous Treatment Reason:
Clinic/Agency Therapist
Outcome

Family History of mental health:

Social Functioning:

Leisure Activities: Hobbies:

Activities with others: Club/Organizations:

Special Skills:

Recent Changes:

Spirituality/Faith/Meaning In Life:

Describe yourself:

Goals:

Current Stressors:

Methods of Coping:

Please check off any of the following that you are presently having difficulty with:

Assertiveness Health Problems Career Choices Parenting alcohol use
Legal Matters Self Concept Sexual Problems Marriage Religion Loneliness
Concentration My Thoughts Suicidal Thoughts Nervousness Energy Sleep
Decision Making Physical Abuse Children Parents Insomnia Education Divorce
Relaxation Ambition Temper Depression Sexual Abuse Shyness
Stress Friends dating Memory Drug use ✔headaches Tiredness Finances Appetite
School Unhappiness Fears Work Confusion Premarital Food Self Control
Sadness In-Laws My Past Guilt