INDEPENDENT MANAGEMENT SERVICES

Conservatorship/Guardianship, SILS/ILS, AFC, Waivered Services, Adult Mental Health Targeted Case Management, ARMHS, CTSS, Psychology/Therapy, Chemical Health Services, Medication Management, Housing Stabilization Services, Social Security Advocacy

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ADULT INTAKE QUESTIONNAIRE

Today's Date: _____________

Client Full Name: ____ DOB: ____________________

Address: ____

Phone: ________________________________ Email: ____

Ethnicity: ☐ White/Caucasian ☐Hispanic/Latino ☐ Black/African-American ☐ Asian
☐Pacific Islander/Native Hawaiian ☐ American Indian or Alaska Native ☐ Other: ___________________

Preferred Language: _______________________________ Preferred Pronouns: ____________________________

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Asexual ☐ Pansexual
☐ Other: ________________________

Currently in School: ☐Yes ☐No Highest level of education completed: __________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse/Partner's Name: ___________________________________ Phone: _________________________________

Employed: ☐Yes ☐No Employer: ____

Emergency Contact Name: ____ Phone: ____________________
Emergency contact relationship to you: _______________________

Do you have minor children: ☐Yes ☐No If yes, do you have custody: ☐Yes ☐No
If yes, please list children's names and ages: ____
____
____

How did you hear about IMS? ____

What are your main concerns at this time and why are you seeking services? ____________________________________
____
____

Please list any social workers, therapists, county workers, or other professionals currently involved in your care:

1. Name/Title: _____________________________________ Phone: ___________________________________

   Agency: ____

2. Name/Title: _____________________________________ Phone: ___________________________________

   Agency: ____

3. Name/Title: _____________________________________ Phone: ___________________________________

   Agency: ____

If you have any previous mental health diagnosis, please list below:

Diagnosis	Who Diagnosed	When

Current Medications (Including vitamins, herbs, and supplements):

Name of medication	Dosage	Frequency	Purpose

Have you had a bad reaction or allergy to any medications? ☐Yes ☐No
If yes, please list: ____
____

Are there any medications you've been told to avoid? ☐Yes ☐No
If yes, please list: ____
____

Do you drink alcohol? ☐Yes ☐No If yes, how much and how often: ___________________________________

Do you smoke cigarettes/e-cigs or use other nicotine products? ☐Yes ☐No
If yes, which and how much: ____

Have you ever done illicit drugs or abused prescription medications? ☐Yes ☐No
If yes, what did you use and when was your last use: ____

Have you ever been to jail? ☐Yes ☐No Have you ever been homeless? ☐Yes ☐No

Please explain any current or ongoing medical conditions that you have that we should be aware of:
____
____
____
____
____

Adult CAGE-AID

In the past three months, have you felt that you should cut down or stop drinking or using drugs? ☐Yes ☐No

In the past three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? ☐Yes ☐No

In the past three months, have you felt guilty or bad about how much you drink or use drugs? ☐Yes ☐No

In the past three months, have you been waking up wanting to have an alcoholic drink or use drugs? ☐Yes ☐No

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____ +	____ +	____
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. 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 difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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

Not difficult at all __________
Somewhat difficult _________
Very difficult _____________
Extremely difficult _________