Reach Your Goal Now with Dr. Cío Hernández

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. If anything is too difficult to answer, leave it blank and we will do it together.

Please fill out this form and bring it to your first session or email it to cio@reachyourgoalnow.com

First, Middle, Last Names and what would you like me to call you?:		
Name of parent/guardian (if under 18 years):		
Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Other_____		
Marital Status: □ Never Married □ Domestic Partnership □ Divorced □ Married □ Separated □ Widowed		
Please list the names and ages of all children	Names	Ages
Physical address:		
Mailing address:		

Home Phone:	May we leave a message? □Yes □No
Cell/Other Phone:	May we leave a message? □Yes □No
E-mail:	May we email you? □Yes □No
Preferred communication?	Home_____ Cell_____ Email _____ Text _____
*Please note: Email, text, and even secure video conferencing is not considered to be a confidential medium of communication	
Emergency Contact	Name and Phone number:
How did you hear about us?	
Have you previously received any type of mental health services, (psychotherapy or psychiatric)?	□ Yes □ No, If yes, name of previous therapist/practitioner:
Are you currently taking any prescription medication?	□ Yes □ No Please lists:
Have you ever been prescribed psychiatric medication?	□ Yes □ No Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)	Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:	
2. How would you rate your current sleeping habits? (please circle)	Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:	☐Falling Asleep ☐ Staying asleep ☐Waking up early and cannot go back to sleep ☐Too much sleep, but still tired.
3. How many times per day you generally exercise? And What types?	
4. Please list any difficulties you experience with your appetite or eating patterns.	
5. Are you currently experiencing overwhelming sadness, grief or depression?	□ No □ Yes, How long?

6. Are you currently experiencing anxiety, panic attacks or have any phobias?	□ No □ Yes If yes, when did you begin experiencing this?
7. Are you currently experiencing any chronic pain?	□ No □ Yes If yes, please describe:
8. Do you drink alcohol more than once a day _____week _____month _____ I don't drink_____?	
9. How often do you engage recreational drug use? Which one/s (circle all that apply)?	Caffeine Marijuana Methamphetamine Cocaine Heroine Inhalants Over the Counter or Prescription Drugs (which ones?)_____ _____ □ Daily □ Weekly □ Monthly □ Infrequently □ Never
10. Are you currently in a romantic relationship?	□ No □ Yes If yes, for how long? _____ On a scale of 1-10, how would you rate your relationship? _____
11. Do you have vision problems? □ No □ Yes Epilepsy? □ No □ Yes Tracking problems □ No □ Yes	
12. What significant life changes or stressful events have you experienced recently?	

ADVERSE CHILDHOOD EXPERIENCES:

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___ If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___ If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___ If Yes, enter 1 __
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___ If Yes, enter 1 __
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___ If Yes, enter 1 __
6. Were your parents ever separated or divorced?
   No___ If Yes, enter 1 __
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___ If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___ If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No___ If Yes, enter 1 __
10. Did a household member go to prison?
    No___ If Yes, enter 1 __

Now add up your "Yes" answers: _ This is your ACE Score_____

ADDITIONAL INFORMATION:

1. Are you currently employed?	□ No □ Yes If yes, what is your current employment situation?
Do you enjoy your work?	□ No □ Yes What is stressful about your current work?
2. Do you consider yourself to be spiritual or religious?	□ No □ Yes Do you attend church services? □ No □ Yes If yes, describe your faith or belief:
3. What do you consider to be some of your strengths?