515-724-8920
888-771-3225
info@mosaicfamilyinc.com
www.mosaicfamilyinc.com

Demographic Information

1. **Please enter the client's information**

First and Last Name

____

Preferred Name

____

Mailing address

____

City, State, and Zipcode

____

Phone number

____

Email address

____

Date of birth (mm/dd/yyyy)

____

Emergency contact (name/relation/phone)

____

Optional: Gender - how do you identify?

____

Gender self-describe (optional)

____

Insurance plan (if self-pay, enter self-pay)

____

Insurance ID number (if not applicable, enter "N/A")

____

Secondary insurance ID number

____

Secondary insurance plan

____

Optional: Which of the following terms best describes the client (check as many as apply)

☐ White/Caucasian ☐ Black/African American
☐ Latino/Hispanic (i.e. Cuban, Puerto Rican, Mexican, Colombian, Costa Rican, Salvadoran, Honduran)
☐ Asian American (i.e. Chinese, Japanese, Filipino, Vietnamese. Cambodian, Korean) ☐ Alaskan Native
☐ Asian Indian ☐ Middle Eastern ☐ Other (enter in next box)

Other race/ethnicity (optional)

____

2. Do you have any needs that you would like us to know about in order to provide you with the best quality of care? (i.e. language preference, literacy level, physical accommodations, provider gender preference, etc.) What do you want us to know about your culture?

____

____

____

____

3. Does the client have a legal guardian that has been assigned by the court? If yes, please provide the guardian's name. The office will need a copy of the documentation evidencing that this person has guardianship of the client.

- ○ No
- ○ Yes

If "Yes," enter guardian name

____

4. Describe what has led you to seek counseling now.

____
____
____
____

5. What type of therapy or service(s) are you seeking?

- ☐ EMDR/Healing Trauma
- ☐ Group evaluation (STEPPS or Stairways)
- ☐ Parenting Assessment
- ☐ Supervised visitation
- ☐ Family Counseling
- ☐ Couple's or marital counseling
- ☐ Play Based Therapy
- ☐ Spiritual or Christian Based Counseling
- ☐ Grief Counseling
- ☐ Stress Management
- ☐ Addiction & Recovery
- ☐ Substance use evaluation ONLY (no desire for ongoing services)
- ☐ Mental health evaluation ONLY (no desire for ongoing services)
- ☐ Other

If "other" please specify

____

6. Who referred you to MOSAIC FAMILY Counseling Center Inc?

- ☐ Word of mouth (friend, family member, co-worker, etc.)
- ☐ Online search
- ☐ Social Media (Facebook, LinkedIn, Instagram, etc.)
- ☐ Des Moines Public School staff
- ☐ Another therapist
- ☐ Primary Care Physician
- ☐ Psychiatrist
- ☐ Other health provider (chiropractor, nutritionist, massage therapist, etc.)
- ☐ Attorney
- ☐ DHS
- ☐ Community meeting
- ☐ Other

If "other" or "another therapist," please specify

____

7. Have you received psychotherapy or counseling in the past?

- No
- Yes

If yes, when was that? Please list the mental health care providers (Counselor / Psychologist / Psychiatrist)' names, contact information, and diagnosis.

____

8. What is your goal for engaging in therapy? How will you know you no longer need therapy?

____

____

____

____

Health History

9. Are you currently under care of a physician?

- No
- Yes

10. If you are currently under care of a Physician, please specify:

	Physician Name	Condition	Type of Treatment
1			

11. List any medications (psychotropic or not) that you have taken in the past or are currently taking If none, enter "none" in box 1

	Medication	Dosage	Since when?	Adverse effects	Currently taking this medication?
1					
2					
3					
4					
5					

12. List any history of hospitalizations or accidents If none, enter "none" in box 1

	Date	Age	Reason
1			
2			
3			
4			
5			

13. List any allergies If none, enter "none."

____

____

____

____

14. Are you sexually active?

- ○ Yes
- ○ No
- ○ Not applicable

15. Which - if any - of the following conditions have you suffered from or experienced? Please use the boxes to indicate the approximate age when affected by such conditions and/or to further specify them:

- ☐ Allergies to _ ______________
- ☐ Abortion ______________
- ☐ Asthma ______________
- ☐ Autism ______________
- ☐ Chicken pox ______________
- ☐ Chronic/serious health problems ______________
- ☐ Diphyheria ______________
- ☐ Ear infection ______________
- ☐ German measles ______________
- ☐ Lead poisoning ______________
- ☐ Mental retardation ______________
- ☐ Miscarriage ______________
- ☐ Mumps ______________
- ☐ Pneumonia ______________
- ☐ Poliomyelitis ______________
- ☐ Pregnancy ______________
- ☐ Red measles ______________
- ☐ Rheumatic fever ______________
- ☐ Scarlet fever ______________
- ☐ Significant injuries ______________
- ☐ Tuberculosis ______________
- ☐ Whooping cough ______________
- ☐ None of these ______________
- ☐ Other(s) ______________

If "other(s)", please specify

____

Childhood and Family History

16. **Parents' current marital status. If a parent is no longer alive, please indicate the parent's marital status before passing:**

☐ Married to each other ______________

☐ Separated for __ years ______________

☐ Divorced for __ years ______________

☐ Mother remarried __ times ______________

☐ Father remarried __ times ______________

☐ Mother involved with someone ______________

☐ Father involved with someone ______________

Additional info ____

17. **List your immediate family members (e.g. biological, foster, adopted, step-family) Feel free to add additional pertinent information in the box below.**

	Name	Relation	Type of relation	Age	If deceased, age at death	Physical and/or mental health concerns
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Additional info ____

18. **What support do you have in your life (Family/Friends/School/Work/Social Activities, etc)?**

____

____

____

____

Substance Use History

19. **Substance use or addictive behaviors status**

- ☐ No history of use or addictive behaviors (self, family members, or significant others)
- ☐ Active use or engagement in addictive behavior (use in the last 3 months)
- ☐ Active use or history of use by family member(s) or significant other(s)
- ☐ Early remission (no use in the last 3-12 months)
- ☐ Sustained remission (no use for 12 months or longer)

20. **Substance use or addictive behavior history**

	Substance/Behavior	Who (self and/or family member)	Age of first use	Method of use	Date of last use
1	Alcohol				
2	Marijuana				
3	Cocaine				
4	Methamphetamine				
5	Hallucinogens				
6	Heroin				
7	Prescription Medication				
8	Caffeine				
9	Nicotine				
10	Sexual addictions				
11	Gambling				
12	Video Games				
13	Shopping				
14	Hoarding				
15	Other substance or addictive hehavior				

If "other," please specify

____

21. **Do you feel you (they) need to cut down on your substance use or reduce your engagement in an addictive behavior?**

- ○ Yes
- ○ No
- ○ Unsure

If yes, please explain

____

22. Have you (they) ever felt the NEED to use or engage in an addictive behavior?

- Yes
- No
- Unsure

If yes, please explain

____

23. Have you (they) ever had blackouts, seizures, unintentional overdose, DUI, arrests while intoxicated or related to drinking or engaging in other substance use?

- Yes
- No
- Unsure

If yes, please explain

____

24. Have you (they) ever had physical fights, assaults during a time you were using substances or engaged in an addictive behavior?

- Yes
- No
- Unsure

If yes, please explain

____

25. Have you (they) ever had relationship consequences at work or school related to substance use or an addictive behavior?

- Yes
- No
- Unsure

If yes, please explain

____

26. Have people annoyed you (them) by criticizing your (their) use of substances or engagement in addictive behaviors?

- Yes
- No
- Unsure

If yes, please explain

____

27. Has anyone given you (them) an ultimatum or told you (them) that they want you (them) to cut back or to stop using substances or stop engaging in addictive behaviors?

- Yes
- No
- Unsure

If yes, please explain

____

28. Have you (they) felt bad, guilty, or afraid of the use of substances or engagement in addictive behaviors?

- ○ Yes
- ○ No
- ○ Unsure

If yes, please explain

____

29. Have you (they) have had a drink or used drugs first thing in the morning to steady nerves, get rid of a hangover or feel better?

- ○ Yes
- ○ No
- ○ Unsure

If yes, please explain

____

30. Have you (they) ever experienced withdrawal symptoms (e.g. nausea, tremors, fatigue, seizures, hallucinations, etc)?

- ○ Yes
- ○ No
- ○ Unsure

If yes, please explain

____

31. If any, which have been the consequences of substance use or addictive behaviors in your (their) life?

- ☐ Arrests
- ☐ Assaults
- ☐ Binges
- ☐ Blackouts
- ☐ Hangovers
- ☐ Job loss
- ☐ Loss of control
- ☐ Medical conditions
- ☐ Overdose
- ☐ Relationship conflicts
- ☐ Seizures
- ☐ Sleep disturbance
- ☐ Suicidal impulse
- ☐ Tolerance changes
- ☐ Withdrawal symptoms
- ☐ Unknown
- ☐ Other(s)

If "other(s)", please specify

____

32. Substance use treatment history If none, enter "none" in box 1

Treatment history	Type of Program	Who (self or family member)	Where	Dates of Treatment	Number of episodes	Length of sober time
1	Inpatient					
2	Outpatient					
3	12 step/recovery focused programming					

33. Is there anything you would like to add about your (their) substance or addictive behavior history?

____

____

____

____

Education and Employment History

34. Are you in school?

- ○ Yes
- ○ No
- ○ Not applicable

If yes, explain

____

35. Are you employed?

- ○ Yes
- ○ No
- ○ Not applicable

If yes, how many jobs have you had in the past 5 years?

____