Utah Healing Center

5284 So. Commerce Dr., Suite C-134 ♦Murray, UT 84107♦Phone: 801-266-4643♦Fax: 801-266-4775

INTAKE SCREENING

Name:	Sex	Date:
Birth Date:	Grade:	Age:

Part 1: Please explain to the therapist why you are coming to the Utah Healing Center:

Part 2: Please check why you are coming to Utah Healing Center (check all that apply to you):

Worry about a lot of things		Death of a loved one	
Heart beating quickly		Experienced a traumatic event	
Headaches or stomach aches		Feel emotionally numb	
Often feel sad		Flashbacks	
Think about hurting yourself		A loss of memory or blocks of time	
Loss of interest in things you like to do		Consume Alcohol	
Easily Distracted		Use Illicit drugs	
Feel like you always have to be talking		Use Tobacco	
Problems in the social environment (i.e. communication or interactions)		Repetitive Patterns (i.e. talking, objects, schedules)	
Struggling with communicating with your partner		Elevated mood or energy that lasted 1 week	
Do you feel like your home is not your home		Decreased need for sleep	

Part 3: Please check any of the following that apply to you:

Sudden and strong fears		Heart beating quickly	
Trouble staying focused		Desire escape from problems	
Restless feelings		Become angry without reason	
Loss of interest in things you like to do		Act aggressively (yelling, shoving or hitting)	
Feel bad about yourself		Drive fast or other risky activities	
Change of appetite		Wake up at night	
Lose control due to a word, phrase, or situation		Toss and turn in bed	
Fume inside and bottle up your feeling		Diarrhea or constipation	
Have trouble falling asleep		Constant thoughts of food	
Wake up too early and struggle returning to sleep		Exercise more than one hour daily	
Feel tired upon waking up		Binge or eat a lot at once	
Stomach pain or nausea		Use prescription drugs	
Pain that a doctor couldn't explain		Constantly Fidgeting	
Start and stop frequent diets		Feel addicted to drugs, alcohol or tobacco	
Deny yourself food when hungry		Tried to hurt yourself	
Use over the counter medicine		Tried to kill yourself	
Wanted to hurt yourself		Have trouble getting out of bad relationships	
Thought about or wanted to kill yourself		Have problems with authority figures	
Wished you were dead		Feel crazy and not know why	
Have Marital problems		Feel like you are being followed	
Feel you don't make a difference in relationships		Feel like you are different people at times	
Hear voices		Feel like you are addicted to something	

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Part 4: If you have witnessed or experienced any of the following, place a mark in the column marked "**S**" (for Self). If a member of your family has witnessed or experienced any of the following, place a mark in the column marked "**F**" (for Family). If you still think about the event and it distracts or disturbs you in some way, **circle** the item.

	S	F		S	F
Divorce			Violent accident (car crash, bad fall etc.)		
Death of a loved one			Domestic violence		
Assault (being hit, thrown, etc.)			Serious illness		
Abuse: Physical, sexual, or verbal			Severe burns		
Serious injury			Feeling rejected by someone important		
Gang violence			Rape		

Part 5: If you are **currently** experiencing any of the following, place a mark in the column marked "**C**" (for current). If you have experienced any of the following in the **past**, Place a mark in the column marked "**P**" (for past). Check **Both** columns if you currently experience the item and have experienced it in the past.

	C	P
Nightmares or fear producing dreams.		
Flashback (sudden memories, feelings or images that don't seem to belong in your life).		
Needing to avoid certain people or places because of the feeling they can evoke.		
Suddenly remembering frightening or upsetting thoughts or memories.		
Feeling like you are re-living a bad experience from the past.		

Part 6: If you are **currently** experiencing any of the following, place a mark in the column marked "**C**" (for current). If you have experienced any of the following in the **past**, Place a mark in the column marked "**P**" (for past). Check **Both** columns if you currently experience the item and have experienced it in the past.

	C	P
A loss of memory from important events (weddings, graduations etc.).		
A loss of memory for large parts of your childhood.		
Unable to account for blocks of time.		
Finding evidence of doing things that you do not remember doing.		
Finding yourself in a place and having no memory of how you got there.		
Finding yourself acting so differently in one situation compared to another that you almost feel like two different people.		

Part 7: Infectious Disease

	Yes	No
Do you have an infectious disease (i.e. Hepatitis, Influenza, HIV/AIDS, Pneumonia, Tuberculosis, etc).		

If yes, please list infectious disease: _____

Part 8: Please list your strengths and weaknesses:
Strengths: _____
Weaknesses: _____

Part 9: If there is anything else you would like the therapist to know please discuss it here: