NorServ Group, Ltd
mental health services ~ www.norserv.com
1322 North River Rd., St. Clair, Michigan 48079
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Intake Questionnaire **Date:**_____

All information provided is kept strictly confidential

Name of Consumer:_____

Home/Mailing Address:_____
street / p.o. box

_____
city **state** **zip code**

Telephone:
Home:_____ Work:_____ Cell:_____

E-Mail Address:_____
May we contact you by e-mail? Yes / No Case sensitive? Yes / No

Date of Birth:_____ Social Security #: _____

Emergency Contact(s):

Name:_____ Telephone#:_____

How did you hear about our group? Who referred you? _____

What are you / your family seeking service for: _____
_____
_____
_____
_____

Employment (please check all that apply):
[ ] Employed & satisfied [ ] Employed & not satisfied
[ ] Unemployed [ ] Student
[ ] Disabled [ ] Military
[ ] Other:_____

Marital History:
[ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated
[ ] Living together / significant other's name:_____
Name of spouse:_____ Date of birth:_____
Marriage date: _____ Divorce date:_____
If there were other marriages, please indicate marriage / divorce dates:_____
_____

Family Information

Children:

Name	Age	Sex	Grade / Occupation	Living with consumer	Bio / Half / Step / Adopted

Parents: [ ] Married [ ] Divorced [ ] Separated [ ] Deceased

Birth Father's Name:_____ Age:_____
Occupation: _____ Education level: _____
Birth Mother's Name:_____ Age:_____
Occupation: _____ Education level: _____
Step-Father's Name:_____ Age:_____
Occupation: _____ Education level: _____
Step-Mother's Name:_____ Age:_____
Occupation: _____ Education level: _____
Adoptive Father's Name:_____ Age:_____
Occupation: _____ Education level: _____
Adoptive Mother's Name:_____ Age:_____
Occupation: _____ Education level: _____

Brothers and Sisters:

Name	**Age**	**Sex**	**Grade / Occupation**	**If deceased, date / cause**	**Bio /Half / Step / Adopted**

Education (check all that apply):

[ ] Currently enrolled: Name of school: _____
last grade completed:_____ current grade:_____
[ ] Special Education certified / services being received:_____
[ ] Did not complete school: last school attended:_____
[ ] GED [ ] Graduated from high school / date: _____
[ ] Post-high school education: _____

Current Medications:

Medication	**Dose**	**How often?**	**Who prescribes?**	**For what?**

Any known drug / other allergies: _____
Frequently taken over the counter medications or herbal products: _____

Past medications that did not work or caused a reaction: _____

_____

Primary Care Physician: _____
Location: _____ Telephone #: _____

Please list any previous inpatient or outpatient mental health treatment (if applicable):

_____

_____

Health History (check all that apply):

	Never	Past	Present	Family history / who
Allergies	[ ]	[ ]	[ ]	_____
Anorexia / Bulimia	[ ]	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	[ ]	_____
Asthma	[ ]	[ ]	[ ]	_____
Broken Bones	[ ]	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	[ ]	_____
Dietary problems	[ ]	[ ]	[ ]	_____
Fainting / Dizzy	[ ]	[ ]	[ ]	_____
Fibromyalgia	[ ]	[ ]	[ ]	_____
Hearing loss	[ ]	[ ]	[ ]	_____
Heart disease	[ ]	[ ]	[ ]	_____
High / Low blood pressure	[ ]	[ ]	[ ]	_____
High / Low blood sugar	[ ]	[ ]	[ ]	_____
Liver disease / jaundice	[ ]	[ ]	[ ]	_____
Major injuries	[ ]	[ ]	[ ]	_____
OB / GYN problems	[ ]	[ ]	[ ]	_____
Obesity	[ ]	[ ]	[ ]	_____
Seizures / Epilepsy	[ ]	[ ]	[ ]	_____
STD's / STI's	[ ]	[ ]	[ ]	_____
Stomach / Intestinal problems	[ ]	[ ]	[ ]	_____
Thyroid problems	[ ]	[ ]	[ ]	_____
Ulcer	[ ]	[ ]	[ ]	_____
Vision loss	[ ]	[ ]	[ ]	_____
Mental health history	[ ]	[ ]	[ ]	_____
Substance abuse history	[ ]	[ ]	[ ]	_____
Chronic pain	[ ]	[ ]	[ ]	_____

Other health issues: _____

_____

_____

_____

Legal Information:

Have you or your family had past involvement with Protective services? [ ] YES [ ] NO
If yes, when: _____

Are you currently involved in a legal case? [ ] YES [ ] NO
If yes, is your treatment court ordered or will it be part of the legal case? _____

_____

Attorney: _____ Location: _____

Have you (past / present) been involved in a custody, traffic, civil or criminal case? [ ] YES [ ] NO

If yes, describe: _____

Community Services you are involved with / receiving:

Services / Supports you care currently receiving (check all that apply):

[ ] Transportation [ ] Maternal supports [ ] YMCA [ ] AA / NA / Alanon
[ ] WIC [ ] SOS [ ] CMH [ ] Faith-based
[ ] Other (describe):_____

Problem Behaviors:

Have people commented about what you say or do? [ ] Yes [ ] No
If yes, describe: _____

List specific behaviors you are having difficulty with:

What are your goals for your treatment services? What would you like to see change?

Any additional information you would like your clinician to be aware of:

Payment for service will be:

[ ] Cash [ ]Check [ ]Charge Card [ ]Insurance (**complete next section**)

Insurance information / guarantor:

Name of Primary Insured:_____
Social Security # of Primary Insured: _____
Address (if different from consumer): _____
Employer:_____
Insurance Plan Name:_____
Policy #:_____ Group#:_____

(please bring your insurance card – we will need to make a copy)

Signature/ person completing form / Relationship to consumer **Date**

Staff signature **Review Date**