Beautiful Mind Therapy, Inc
Phone: 708-695-4808 Fax: 888-965-7017
975 East Nerge Road, Suite W40, Roselle, IL 60172-4809

Immigration Intake Assessment

The information asked below is to help me work with you. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law.

First Name: Middle Name: Last Name:

Home Address:

City State Zip

Home phone number: Cell number: Work number:

DOB: ______________ Age: _______ Gender: _____________

E-mail: ____
Would you like to receive notifications from us? ☐ Yes ☐ No

Emergency Contact: Phone: Relationship:

Referring source/attorney: ____

What type of case do you have? ☐ Spousal abuse (**VAWA**) ☐ Victim of a crime (**U-Visa**)
☐ **Hardship** (you are a citizen and your spouse is undocumented) ☐ **Asylum** (you've fled your home country and are afraid to go back) ☐ Other: ______________________________

Who is filling out this questionnaire? ☐ Self ☐ Other ______________________

Who do you live with?
Name ______________________ Relationship__________ Date of Birth_____________
Name ______________________ Relationship__________ Date of Birth_____________
Name ______________________ Relationship__________ Date of Birth_____________
Name ______________________ Relationship__________ Date of Birth_____________
Name ______________________ Relationship__________ Date of Birth_____________
Name ______________________ Relationship__________ Date of Birth_____________

How long have you lived in the current place? __________ Do you rent or own your home? _________

When did you enter the United States:

Arrival date:	Departure date:	What visa did you enter with?	What city/state did you live in?
1. ______________	______________	______________________	____________________
2. ______________	______________	______________________	____________________
3. ______________	______________	______________________	____________________

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Presenting Concerns

Why are you seeking treatment at this time?____
____

When did your current symptoms/issues begin? ____
____

What stressors may have contributed to the current complaint or problem? _______________________
____

Primary Concerns (check all that apply):

___ Depressed/sad/feeling down
___ Loss of interest in activities
___ Can't seem to enjoy myself
___ Feeling unhappy about myself
___ Crying spells
___ Difficulty enjoying things
___ Loneliness
___ Trouble sleeping/nightmares
___ Poor Appetite
___ Trouble concentrating
___ Tiredness
___ Procrastination/difficulty making decisions
___ Feeling guilty
___ Feelings of helplessness
___ Feelings of hopelessness
___ Feelings of worthlessness
___ Low self-esteem
___ Thoughts about death
___ Suicidal thoughts/plans
___ Homicidal thoughts/plans
___ High/low energy
___ Racing thoughts
___ Angry/irritable
___ Hearing voices, seeing things that are not there
___ Paranoid thoughts
___ Anxiety
___ Excessive worry
___ Panic attacks
___ Repetitive thoughts
___ Rituals
___ Perfectionism
___ Trouble socializing/making friends
___ Feeling rejected by others
___ Difficulty expressing feelings
___ Difficulty saying "No" to others
___ Interpersonal difficulties with men/women
___ Difficulties with children
___ Interpersonal difficulties with parents
___ Roommate/friendship difficulties
___ Marital problems
___ Problems with work/school
___ Financial problems
___ Chronic/terminal illness
___ Loss of loved one
___ Sexual problems
___ Use of alcohol
___ Use of drugs
___ Addictions (Internet, porn, shopping, gambling)
___ Preoccupation with food, diet, or exercise
___ Feelings of loss of control over eating
___ Dissatisfaction with my appearance body
___ Restricting food
___ Binging/purging behaviors
___ Self-harm/cutting/burning yourself

Social History

What city/state/country did you grow up? ____

Who did you live with? ____

Who raised you? Biological/adoptive/foster/step-parents/others ______________________________

Until what age they raised you? ____

Describe people who raised you (What did they do for a living, hobbies, special interest, personalities):
____
____
____
____

Did you meet normal developmental milestones (walking, talking, reading, school, career, etc.)?
____

Mother's name: ___________________________________ Mother's date of birth: _____________
Father's name: ___________________________________ Father's date of birth: _____________

Siblings:
Name:____ Date of birth: __________________

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Name:____ Date of birth: ____________________
Name:____ Date of birth: ____________________
Name:____ Date of birth: ____________________
Name:____ Date of birth: ____________________
Name:____ Date of birth: ____________________

Where do your parents and siblings reside? ____

What type of relationship did you have with your parents and siblings?
____

How was your social life growing up (Very good, good, average, poor)? ____________________________

Did you have any friends and date? ____

Did you participate in any extracurricular activities (sports, arts, etc.)? ______________________________

Did you have any hobbies (painting, reading books, etc.)? _______________________________________

What languages do you speak? ____

Relationship History

Describe current marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated
☐ Live with a partner but not married ☐ Other ____

Past marital/relationship history (start from most recent):

Name of your partner/spouse	Date of Birth	Marriage Date	Divorce Date	Child's name and date of birth
1. ____________________	__________	__________	________	1. ______________________________
				2. ______________________________
				3. ______________________________
				4. ______________________________
2. ____________________	__________	__________	________	1. ______________________________
				2. ______________________________
				3. ______________________________
				4. ______________________________
3. ____________________	__________	__________	________	1. ______________________________
				2. ______________________________
				3. ______________________________
				4. ______________________________

Who do you spend the most time with (Family, friends, co-workers, etc.)? ______________________________
____

How would others describe you? ____
____

Do you have any hobbies? ____

What do you do to relax and unwind? ____
____

What are your strengths? ____
____

What are your weaknesses? ____
____

What are your long-term goals? ____
____

Trauma History

Have you ever experienced the death of someone you cared about? _____________________________
____

Have you ever experienced physical, emotional, or sexual abuse or neglect? ______________________
____

Have you ever been a victim of a violent crime such as assault, mugging, rape, etc.? _________________
____

Medical Treatment History

Name of your doctor: ____________________ Date started: ______________ Date finished: _______________
Name of your specialty doctor: ____________________ Date started: __________ Date finished: ___________
Name of your psychiatrist: ____________________ Date started: ______________ Date finished: ___________
Name of therapist: ______________________ Date started: ______________ Date finished: ________________

Have you been **hospitalized** before? ☐ Yes ☐ No Did you have any surgeries? ☐ Yes ☐ No

Name of the hospital:	Date admitted:	Date discharged:	Reason for admission:

Have you been at any **outpatient program** before Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)? ☐ Yes ☐ No

Name of the program:	Date admitted:	Date discharged:	Reason for treatment:

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List of your current **medications**:

Name:	Dosage:	Date started:	Prescribing doctor's name:
______________________________	______________	______________	_________________________________
______________________________	______________	______________	_________________________________
______________________________	______________	______________	_________________________________
______________________________	______________	______________	_________________________________
______________________________	______________	______________	_________________________________
______________________________	______________	______________	_________________________________

History of **suicide attempts**:

Date:	How you tried to harm yourself?	What happened?
____________	_______________________________	____
____________	_______________________________	____

Do you have any **conditions/disabilities** that I need to be aware of?

Diagnosis:	When were you diagnosed?	Name of your treating doctor:
____	_______________________	___________________________
____	_______________________	___________________________
____	_______________________	___________________________
____	_______________________	___________________________
____	_______________________	___________________________

Do you have chronic **pain**? ☐ Yes ☐ No When did you current pain begin? ________________________
If yes, where does it hurt? ____
How intense is your pain (0 – no pain and 10 extreme pain) ____

Do you have **headaches**? ☐ Yes ☐ No How often do you have headaches per week? _________________
How intense are your headaches (0 – no pain and 10 extreme pain) ________________________________

Do you have a family history of medical or psychiatric illness/addiction (diagnosis, hospitalizations, suicide)?
____

Education

Name of the **high school** you graduated/last attended____
What city and country was your school located? ____
Graduation month and year ___________ What grades did you receive (A's 10/10, etc) _______________
What was your favorite subject in school? _________________ Did you have to repeat any grades? _________
Describe any discipline problems in school (suspensions, detentions, police) _____________________________

Name of the **college/university** you graduated/last attended ____
Degree: _________________________________
What city and country was your college/university located? ____

Graduation month and year ___________ What grades did you receive (A's 10/10, etc) __________

What was your favorite subject in college/university? ____

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Work History

Are you currently employed? ☐ Yes ☐ No Length of time at this job ____________________

What is your occupation? ____

What is the name and city of your employer: ____

Describe any times in the past 12 months that your mental/emotional complaints caused you to miss work:
____
____
____

Previous work history (start from most recent):

Company Name	Position	Start Date	End Date	Reason for leaving	Fired?

Legal History

Past criminal charges:
Legal Charge ____________________ Date ___________
Result (incarceration, parole, etc.) ____

History of fights/assaults: ____

Are you a registered sex offender? __________ Do you abuse others verbally, physically, sexually? _______

Military history

Please list:
Branch of service ______________________ Start date _____________ Stop date ________________

Where you discharged dishonorably? ☐ No ☐ Yes, why? ____
Describe any discipline problems while in military ____