Acknowledgement of Receipt

I acknowledge that I have received the Behavioral Health Branch Brochure that contains the following information:

1. Client's Expectations and Responsibilities
2. Customer Rights Policy and Procedures
3. Privacy Act Statement
4. Program Information (Community Counseling Program, Family Advocacy Program-New Parent Support Program, Substance Abuse Counseling Center)
5. Limits to Privacy and Confidentiality

My signature confirms that I have received and understand all the contents of the aforementioned documents as it pertains to Marine and Family Programs Behavioral Health services. My signature establishes informed consent for the clinical services provided to me and/or my family. Furthermore, my signature shall serve as verification that the information provided on the Intake Information form is accurate and I understand that failing to uphold my responsibility may result in service delivery delays as well as not being able to participate in planned events or services.

Print Client Name :_____

Clients Signature: _____ Date: _____

If applicable,
Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____
**Consent for Child to receive services must also be obtained prior to providing clinical services for a minor.

Witness Signature: _____ Date: _____

Print Witness Name :_____

USMC Marine & Family Programs

Intake Information

FOUO – PRIVACY SENSITIVE WHEN FILLED IN

Name:		Today's Date:
Date of birth:	Gender:	DoDID or SS#:
Racial/Ethnic Background:		
Who referred you?		
Current Address: ☐Civilian Housing or ☐Military Housing Permanent Address:		
Phone Number 1: ☐ Cell ☐ Home ☐ Work Phone Number 2: ☐ Cell ☐ Home ☐ Work How would you like staff to contact you? Is it okay for staff to leave a message for you at the numbers above? ☐Yes ☐No		
Email Address (Personal):	Email Address (Work):	

Presenting Concern:

What brings you here today?

Have you sought treatment for this before now (if yes, when)?

Military History (if applicable):

Branch of service: ☐Marine Corps ☐Navy ☐Air Force ☐Coast Guard ☐DOD Agency ☐Army ☐Other:

Duty Status: ☐Active ☐Reserves ☐Spouse ☐Child ☐Family Member ☐DoD Caregiver ☐Civilian (OCONUS)

Highest rank:

If you are not currently active duty, what prior service do you have?

Branch: Dates: Type of Discharge?

Deployment/combat history (location/date):

Have you had any injuries while in the military?

USMC Marine & Family Programs

Intake Information

FOUO – PRIVACY SENSITIVE WHEN FILLED IN

Have you ever experienced any head trauma due to an explosion, a blast, a fall, a motor vehicle accident, sports injury or other incident? ☐ Yes ☐No

If Yes, when?

Did you lose consciousness, "see stars," or have a sense of being dazed, or are you unable to recall the injury? ☐Yes ☐No

Did you receive treatment or see a medical professional as a result of the trauma? ☐Yes ☐No

If Yes, provide details.

Do you want to be referred to a medical professional for any concerns you might have that you think might be related to a possible head trauma or concussion? ☐Yes ☐No

What other vocational/other training have you received in the military?

If Active Duty (if not active duty, fill this out with sponsor's information):

Rank: Command: Dates of Service: MOS:

Command/Unit and Command/Unit phone number:

Commander's/Supervisor's name and phone number:

Major Command: Battalion: Company:

Your EAS date: Your PCS date:

If Reserves: Location: Unit Commander:

If not Active Duty:

Occupation: _____ Employer: _____ Sponsor: _____

Employment History (if not in the military):

Are you currently employed? ☐Yes ☐No

If you were ever terminated from a job, please explain.

Source of Income: (check all that apply)

☐Employment ☐Temporary Assistance for Needy Families/AFDC ☐WIC ☐SSI ☐SSDI

☐Survivor's Benefits

Relationships/Support Systems/Living Arrangements:

Current Status: ☐Married ☐Divorced ☐Separated ☐Widowed ☐Significant Other

☐Domestic Partnership ☐Single

How many times have you been married: _____ If currently married, how long? _____

Do you live on base housing? ☐Yes ☐No ☐Do you rent or ☐Own your home?

Who do you live with and please describe your home life.

USMC Marine & Family Programs

Intake Information

FOUO – PRIVACY SENSITIVE WHEN FILLED IN

Do you have any children?

Name	Age	Gender	Date of Birth	Where do they reside

Educational Background and Literacy Level: Highest level of education achieved?

Please explain why if you left high school, vocational school, or college without graduating.

Were you ever diagnosed with learning disabilities? ☐Yes ☐No
Please describe any behavioral, learning disabilities, or experiences that are significant to your educational history or learning ability.

Are you interested in furthering your education? ☐Yes ☐No

Legal Information:

Please list legal proceedings you or your family members are involved with (divorce, military protection order, civil protection order, civil, criminal, traffic, court martial).

Who	Charges	Which Court	Probation Information	Upcoming Hearing/Trial Dates

Do you have a history of receiving traffic violations? ☐Speeding ☐DUI ☐DWI ☐Other:

Physical Health: Please list any medical conditions or diagnosis you currently have.

Diagnosis	Date Diagnosed	PCM/Doctor	Treatment Received	Location of Treatment	Medication	Ever hospitalized for this condition?

If the medications are not helping/working for you, provide details of which medications and your response to them.

Please list which medications you are allergic to and the reaction you have to them.

Are you being seen by any other agency? ☐Naval Health ☐DSS ☐Chaplain ☐MFLC ☐Military OneSource
☐Other: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)