Rooted Mind
COUNSELING CENTER

1247 Milwaukee Ave. Suite# 208 Glenview, IL. 60025~224.257.4190

Clinical Intake Assessment

Name:_____Date:_____

Precipitating Factors:

In general terms, what brings you to therapy at this time?

_____

_____

_____

Please *circle* the severity of your symptoms: **Mild Moderate Severe Extremely severe**

History:

Have you been in therapy before or received prior help for your current and/or different concern? ____**no** ____**yes**
Previous therapist name _____

1. Treatment Type:_____Date_____

   Diagnosis:_____ Was it helpful_____

2. Treatment Type:_____Date_____

   Diagnosis:_____Was it helpful _____

Have you ever been hospitalized for a psychiatric condition? **Yes No**

If yes, specify_____

Self-Harm History:

Past suicidal gestures, attempts or thoughts? **Yes**____ **No**_____

Desire to harm someone else? **Yes**____ **No**_____

Do you want to harm yourself now? **Yes**____ **No**____

Do you have thoughts about killing yourself? **Yes**____ **No**_____

If you answered "yes" to any of the questions above, please specify:

_____

_____

_____

Legal History:

Have you ever been charged with a crime or served time in jail? **Yes No**

Have you had a DUI? Yes No Please specify:_____

Family Mental Health Histroy:

	Please Circle	**List Family Member**
Depression	Yes/No	_____
Anxiety	Yes/No	_____
Suicide Attempts	Yes/No	_____
Schizophrenia	Yes/No	_____
Eating Disorders	Yes/No	_____
Domestic Violence	Yes/No	_____
Alcohol/Substance Abuse	Yes/No	_____

Symptom Checklist

Please check any items that apply to you. Feel free to add other concerns on the bottom.

CAREER OR SCHOOL CONCERNS

____Unemployment

____Financial

____Career, goals, or choices

____School or learning difficulties

RELATIONSHIP & FAMILY CONCERNS

____Divorce or Separation

____Relationship Problems

____Parenting

____Communication

____Infidelity

GENERAL LIFE EVENTS

____Grief and Loss

____Life balance concerns

____Legal matters

____Other (please specify):

MEDICAL & HEALTH CONCERNS

____Headaches, neck or back pain (chronic)

____Health, illness or medical concerns

____Sexual Dysfunction

____Medications or treatment

MOOD

____Weight/appetite change

____Energy level change

____Sleep disturbance

____Anger or temper problems

____Difficulty concentrating

____Frequent crying spells

____Loss of interest

____Feelings of Hopelessness

____Depression/Sadness

____Agitation or inability to relax

____Guilty feelings

____Frequent mood swings

____Self-isolation

____Low self-esteem/self-hatred

____Diminished sex drive

____Giving your personal belongings away

____Thoughts about death/suicide

____Seeing things/Hearing voices

____Rapid speech or racing thoughts

____Need for admiration

____Feelings of superiority/inferiority

ANXIETY/WORRY

____Panic or anxiety attacks

____Worry something terrible will happen

____Reluctant to go somewhere

____Avoid being alone

____Fearful of new situations or people

____Engage in repeated behaviors (counting Cleaning, hand washing, etc.)

____Excessive worrying

____Recurrent flashbacks/nightmare

____Numbness

____Feeling disconnected

____Suspiciousness of others

ATTENTION

____Poor attention span

____Trouble finishing tasks

____Problems organizing

____Avoiding tasks

____Fidgety/squirmy

____Restlessness

____Frequent interruption of others

BEHAVIOR/CONDUCT

____Frequent fighting/violence

____Legal problems

____Deliberately setting fires

____Use of weapons

____Cruelty to animals

____Impulsive sexual activity

____Gambling

____Alcohol/Drug abuse

____Self-injury

____Past suicide attempts

____Poor judgment/irresponsibility

OTHER

____Oversensitivity to rejection/criticism

____Overeating/Vomiting

____Fear of weight gain

____Sexual identity concerns

Other symptoms not listed, or further comments about any of the above:

_____
_____
_____
_____

STRENGHTS:

In work setting: _____

In social setting: _____

In home setting: _____

Special Interests / Hobbies: _____