INTAKE ASSESSMENT FORM

Please provide the following information and answer the questions below. Please note; **information you provide here is protected as confidential information.** Please fill out this form and sign, bring it to your first session.

FULL NAME OF PATIENT: _____TODAY'S DATE :_____

NAME OF PARENT/GUARDAIN (IF UNDER 18 YEARS) _____

PATIENT BIRTHDATE_____/_____/_____ AGE_____ GENDER_____

ADDRESS:_____

CITY:_____STATE:_____ ZIP_____

HOME PHONE: _____WORK : _____CELL _____

EMAIL: _____

Please note email is not considered to be a confidential medium of communication.

RACE:_____ RELIGION:_____

CULTURE CONSIDERATIONS:_____

EDUCATIONAL LEVEL: _____ PATIENT'S SOCIAL SECURITY NUMBER : _____

PATIENT'S OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPERATED [ ] NEVER MARRIED

YEARS MARRIED:_____ YEARS DIVORCED_____

ARE YOU CURRENTLY IN A ROMANTIC RELATIONSHIP? _____IF YES, FOR HOW LONG? _____

ON A SCALE OF 1-10 HOW WOULD YOU RATE YOUR RELATIONSHIP? _____

NUMBER OF CHILDREN AND AGES_____

DO YOU LIVE ALONE OR WITH FAMILY OR FRIENDS_____

PLEASE LET US KNOW WHO REFERRED YOU TO THIS OFFICE? _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE #: _____ WORK #:_____

IF YOU HAVE OBJECTIONS TO OUR OFFICE MAKING CONTACT WITH YOU AT HOME OR WORK REGARDING APPOINTMENTS, PLEASE NOTE HERE:

SIGNATURE-- “By signing below, I give my permission to Reflections & Wellness Counseling to send communications to me at the locations indicated above and understand that I must provide notification in writing of any changes or restrictions to communication locations. I understand that Reflections Wellness Counseling cannot be held responsible for confidentiality breaches of electronic correspondence to/from Reflections Wellness Counseling. I give my permission to Reflections Wellness Counseling to contact my Emergency Contact listed above. ”

_____ _____

(Client's Signature or Parent/Guardian's Signature if client is under age14) Date

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER’S FULL NAME: _____SSN _____

FATHER’S PLACE OF EMPLOYMENT: _____WORK PHONE: _____

MOTHER’S FULL NAME: _____SSN: _____

MOTHER’S PLACE OF EMPLOYMENT: _____WORK PHONE:_____

IF PATIENT IS A STUDENT, HIS/HER GRADE: SCHOOL:_____

WHO IS RESPONSIBLE FOR PAYMENT OF SERVICES? _____

ADDRESS, IF DIFFERENT THAN THAT OF PATIENT: _____

PRIMARY INSURANCE COMPANY: _____

POLICY NUMBER: _____

GROUP# _____

INSURED’S NAME: _____ INSURED’S EMPLOYER: _____

INSURED’S DATE OF BIRTH: _____

INSURED’S SSN:_____

ALLERGIES:_____

PREVIOUS MEDICAL/HEALTH CONCERNS: _____

_____

PREVIOUS SURGERIES:_____

CURRENT MEDICATIONS And DOSGES: _____

_____

PRESCRIBER:_____

Have you taken medication for a mental health condition (depression, anxiety, ADD etc)?
_____yes_____no

Is there a family history of mental health or substance abuse issues: _____yes _____no

Have you previously received any type of mental health services (Psychotherapy, Psychiatric Services, Counseling)? _____yes _____no

If yes, when and where? _____

Have you ever been hospitalized for psychiatric reasons/when_____

Have you ever had a mental health diagnosis? _____ What diagnosis? _____ By Whom? _____

Are you current or have you seen a therapist or psychiatrist in the last 6 months? _____

If yes who? _____

Last appointment? _____

List any support groups you have attended in the past or presently:

_____

How would you rate your current physical health (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing:

Please list any sleep problems you are currently experiencing?

How many times per week do you generally exercise?

Please list any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief, or depression? [ ] Yes [ ] No

If yes, approximately how long?

Are you currently experiencing anxiety, panic attacks, or have any phobias?

If yes, when did you begin to experience this?

Are you currently experiencing any chronic pain?

If yes, please describe:

Any physical characteristics or body image a concern? Explain:

Is sexual functioning an area of concern for you? Explain:

Have you ever experienced any of the following:

Recent loss (death of loved one, job loss, divorce etc):

_____yes _____no

If yes, please explain:

Attempted suicide: _____yes _____no

If yes, when: _____

Do you currently or have a history of self harm?

If yes, please explain:

Do you have a history of any legal charges? [ ] Yes [ ] No

If yes, explain:

Are you currently on probation or parole? [ ] Yes [ ] No

Is treatment court ordered? [ ] Yes [ ] No

Please check any of the symptoms you have experienced within the past 4 months:

_____ Appetite Disturbance _____ Sleep Disturbances

_____ eating less or more _____ trouble falling or staying asleep

_____ weight loss or gain _____ sleeping too much or too little

_____ binging or purging _____nightmares

_____ Sadness or tearfulness _____ Fatigue/decreased energy

_____ Decreased interest in activities or relationships

_____ Isolating from others

_____Sexual disturbances or dissatisfaction

_____ Feeling worthless _____ Worry or anxiety

_____ Racing thoughts _____ Mood swings

_____ Anger or irritability _____ Feeling hopeless

_____ Guilt, shame or regret

_____ Difficulty concentrating or easily distracted

_____ Procrastination _____ Hyperactive or excessive energy _____ Feeling paranoid
_____ Financial difficulties

_____ Excessive behavior (spending sprees,etc)

_____ Panic attacks _____ Feeling stressed _____ Feeling nervous

_____ Self-Harming or destructive behaviors

_____ Feeling out of control _____ Fearful

_____ Obsessive or compulsive thoughts/behavior

_____ Work-related problems _____ Perfectionism

_____ Impaired impulse control _____ Addictive behaviors

_____ Low self esteem

_____ Difficulty getting along with family/friends/co-workers

_____ Legal problems or involvement

_____ Hallucinations (auditory or visual)

_____ Job loss, job change or retirement

_____ Marital dissatisfaction or conflicts

_____ Thoughts about hurting yourself

_____ Thoughts about death

_____ Thoughts of hurting someone else

Do you have a history prior to the last 4 months of experiencing any of the above symptoms? Explain:

How would you describe your social life?

Substance Use

Do you drink alcohol more than once a week? [ ] Yes [ ] No

If yes, how often?

Is alcohol an area of concern for you? [ ] Yes [ ] No

If yes, explain:

Is recreational drug use an area of concern for you? [ ] Yes [ ] No

If yes, how often do you engage in the use of recreational drug use?

Daily, Weekly, Monthly

Explain:

Do you ever over take prescribed medications? Run out prior to being able to have your prescriptions filled? If yes, explain:

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sibling, ETC.)

Alcohol/Substance Abuse	Yes/No Who
Anxiety	Yes/No Who
Depression	Yes/No Who
Domestic Violence	Yes/No Who
Eating Disorders	Yes/No Who

Obesity	Yes/No	Who
Obsessive Compulsive Behavior	Yes/No	Who
Schizophrenia	Yes/No	Who
Suicide Attempts	Yes/No	Who
Other Mental Health Diagnosis	Yes/No	Who

Additional Information

Briefly describe your current social life/activities/day to day activities:

Chief Complaint-Main Reason for seeking therapy now?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

Is there anything else you feel we should know, or that you are concerned about?

Printed Name Signature Todays Date