

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 bring it to your first session.

Today's Date: _____

GENERAL INFORMATION

Name: _____

(Last)

(First)

(Middle Initial)

Birth date: ____/____/____ Age: _____ Gender: [] Male [] Female [] _____

Address: _____
(Street and Number)

(City)

(State)

(Zip)

Home Phone: () May we leave a message Yes No

Cell/Other Phone: () May we leave a message Yes No

E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Race: _____

Cultural Considerations: _____

Religion:(if applicable) _____

Education

High School: _____
(Where) (Last grade completed) (Graduated? Y or N)

Post High School Education:

Explain:

Is or was school performance a concern for you?

If yes, explain:

Marital Status

Single Married Divorced Separated Never

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? _____

What significant life changes or stressful events have you experienced recently? _____

Children:

Name	Age	Sex	Occupation or Grade	Living with Client	Biological, Adopted, or Step

Other Household Members

Name	Age	Relationship to Client

Who currently lives in your household?

Describe your relationship with:

Parents: _____

Siblings: _____

Extended Family Members: _____

Husband/Wife/Partner / Domestic Partner /Significant Other:

Your Children: _____

Health History

Primary Physician: _____

Primary Physicians Address: _____

Primary Physicians Phone: _____ Date of Last Exam _____

Please List Allergies if Any _____

Have you previously received any type of mental health services (Psychotherapy, Psychiatric services, ECT.)?

Yes _____

No _____

If yes, when and where?

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

Was support group attendance helpful?

Are you currently taking any prescription medications?

Yes _____

No _____

Please list:

Have you ever been prescribed psychiatric medication?

Yes _____

No _____

Please list:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

*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: _____

*How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing: _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

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: _____

Are any physical characteristics or body image a concern? Explain:

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

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:

How often do you engage in recreational drug use?

Daily_____

Weekly_____

Monthly_____

Never_____

Is recreational drug use an area of concern for you? Yes_____ No_____

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 ECT.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Abuse History

Have you experienced physical, sexual or emotional abuse? Yes___ No___

If yes, explain_____

Legal History

Do you have a history of any legal charges? Yes_____ No_____

If yes,
explain_____

Are you currently on probation or parole? Yes_____ No_____

If yes,
explain_____

Is treatment court ordered? Yes_____ No_____

Employment

Are you currently employed? Yes_____ No_____

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

Additional Information

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?

X

Signature of Person Completing Form