Intake Assessment

Please use the back of this form if need more room to complete questions

Date: ________________________

Client name: _____________________________**Date of Birth:** _________________

Age: ______ **Marital Status:** ________________________

Address ________________________________ **City** ________________ **Zip** ______

Home phone ____________________ **Work phone** ___________________

Cell phone ______________________ **Other**_________________________

Emergency Contact (Nearest relative or friend)_________________ **Phone** ______

Person Financially Responsible ___________________**SS#** __________________

Employer ____________________________ **Address**_________________________

Preferred Language of Patient:_______________________

Referral Source:____

☐ **Victom's Compensation County:** ___________________________

Please describe in detail why you are pursuing therapy at this time including background regarding the primary concern.

Check all symptoms that apply past or present:

- ❏ **Anxiety:** ☐ excessive worry ☐ fear of impending harm ☐ panic attacks restlessness ☐ sweaty hands ☐ nightmares ☐ school anxiety ☐ difficulty with transitions ☐ separation anxiety ☐ racing heart ☐ difficulty breathing
- ❏ **Appetite:** ☐ eats too much ☐ eats too little ☐ overweight ☐ underweight ☐ restrictive diet

- ❑ **Nutrition Problems:** ☐ unhealthy choices ☐ cravings ☐ large portions
- ❑ **Attention:** ☐ Attention Deficit/ Hyperactivity ☐ poor attention ☐ disruptive ☐ easily description easily distract ☐ forgetful ☐ does not listen ☐ in impulsive ☐ hyperactive ☐ fidget ☐ unable to stay on task ☐ excessive talking ☐ poor follow-through tasks ☐ avoidance of tasks that require sustained mental effort ☐ difficulty with organization ☐ interrupts or intrudes on others ☐ impatient ☐ loses things
- ❑ **Autism:** ☐ Abnormal Body Posturing or Facial Expressions ☐ Abnormal Tone of Voice ☐ Poor Eye Contact ☐ Behavioral Disturbances ☐ Deficits in Language Comprehension ☐ Delay in Learning to Speak ☐ Flat or Monotonous Speech ☐ Inappropriate Social Interaction ☐ Intense Focus on One Topic ☐ Lack of Empathy ☐ Lack of Understanding Social Cues ☐ Learning Disability or Difficulty ☐ Not Engaging in Play With Peers ☐ Preoccupation With Specific Topics ☐ Problems With Two-Way ☐ Conversation ☐ Repeating Words or Phrases ☐ Repetitive Movements ☐ Self-Abusive Behaviors ☐ Sleep Disturbances ☐ Social Withdrawal ☐ Unusual Reactions in Social Settings ☐ Odd Words or Phrases
- ❑ **Conduct Problems:** ☐ aggressive ☐ oppositional ☐ defiant ☐ assaulted ☐ explosive temper ☐ disobeys rules ☐ argumentative ☐ threatens others ☐ bullies/ intimidates ☐ blames others for Behavior ☐ deliberately annoys others ☐ easily annoyed ☐ angry ☐ resentful ☐ excessively negative ☐ difficult to manage
- ❑ **Depression:** ☐ depressed mood ☐ sad ☐ irritable ☐ mood reactivity ☐ low self-esteem ☐ cheerfulness ☐ energy/ fatigue ☐ poor concentration ☐ hopelessness ☐ restlessness ☐ decreased energy ☐ hopelessness ☐ worthlessness
- ❑ **Dissociative:** ☐ stairs off ☐ periods of not answering questions when talked to ☐ amnesia ☐ not feeling connected to your own body ☐ developing different identities
- ❑ **Energy:** ☐ low energy ☐ high energy
- ❑ **Mania:** ☐ high energy/activity ☐ excessive talking ☐ increased goal-directed behavior ☐
- ❑ **Obsessive/ Compulsive:** ☐ repetitive thoughts ☐ ritualistic behavior ☐ obsessive thinking/behavior

- ❏ **Psychosis:** ☐ delusions ☐ hallucinations ☐ paranoia
- ❏ **Somatic:** ☐ complaints of physical sickness ☐ frequent ailments
- ❏ **Sleep:** ☐ trouble falling asleep ☐ nocturnal awakenings ☐ nocturnal awakenings
- ❏
- ❏ **Suicide/Self-harm:** ☐ thoughts of suicide in the past ☐ current thoughts of suicide ☐ history of suicide attempt ☐ history of self-harm
- ❏ **Trauma:** ☐ victim of crime ☐ re-experiencing trauma ☐ sexual abuse
- ❏ **Grief:** ☐ crying ☐ lack of engagement ☐ recent loss
- ❏ **Relationship Difficulties** ____

Previous Mental Health History:

- ❏ **Participated in counseling in the past (list provider(s) and dates attended)** ____
- ❏ **Previous psychological testing (describe)** __________________________
- ❏ **Previous diagnosis** ____
- ❏ **Previous Hospitalization(s)** ____________________________________
- ❏ **Suicidal ideation:** ☐ thought ☐ plan ☐ intent ☐ self-harm ☐ attempt ☐ hospitalization
- ❏ **Past Psychotropic Medications:** ______________________________
- ❏ **Residential Treatment** ____
- ❏ **Outpatient Treatment** ____

Birth/Developmental History:

- ❏ Age of mother at conception ______________________
- ❏ Concerns during the course of mother’s pregnancy (Medication or drug use, full-term, fetal distress, weights, APGAR scores) _______________________
- ❏ Were your developmental milestones met at appropriate ages ___________________

Medical History:

- ❏ List health concerns ____
- ❏ History of head injury with loss of consciousness ________________________
- ❏ History of Medical hospitalizations___________________________________
- ❏ History of surgeries____
- ❏ Medical diagnosis____
- ❏ Date of last physical exam______________________
- ❏ Weight fluctuations 10 lb within the last 3 months_______________________
- ❏ Special diet____
- ❏ Food allergies___________________________
- ❏ Sleeps concerns
  - ❏ Difficulting falling asleep ____________________
  - ❏ Nightmares _____________________________
  - ❏ Wakes during the night _____________________

- ❏ Number of naps in the day ____________________

Family History:

Client lives at home with:
Name: ________________________________ Age: ____ Relationship: _________
Name: ________________________________ Age: ____ Relationship: _________
Name: ________________________________ Age: ____ Relationship: _________
Name: ________________________________ Age: ____ Relationship: _________
Name: ________________________________ Age: ____ Relationship: _________
Name: ________________________________ Age: ____ Relationship: _________

List biological parents names ____
Were your parents separated/divorced ________
Describe times client has been separated from primary caregiver _____________
List practicing religion ______________________________
Describe your relationship with your biological mother_______________________
Describe your relationship with your biological father _______________________
Describe the your relationship with your siblings____________________________
Describe your relationship with your step-parents ___________________________
List family members who have mental health diagnosis _____________________
List family members who have a medical diagnosis_________________________
How long have you lived at your present location? __________

Interests/Activities:

Current employment____
Hobbies____
Weekly physical activities ____

Educational History:

Last grade completed___________________
Individualized education plan (IEP) special education designation or 504________
List learning difficulties____________________________

Sexual History:

Sexual orientation ___________________
List marital status ________________________
Currently dating _____________________
Sexually active ________________________________

Trauma/Abuse:

Describe trauma/ abuse history____

Legal Involvement:

- ❏ Client has some legal history____________________
- ❏ Current legal involvement____________________________

Substance Use History:

- ❑ Client currently uses substances (list) ___________________________________
- ❑ Client used substances in the past (list)___________________________________
- ❑ When did substance use start ____

Family Psychiatric History:

- ❑ Siblings_____________________________
- ❑ Biological mother ________________________
- ❑ Biological father ______________________________
- ❑ Other family members ______________________________

Current Medications

- ❑ Over-the-counter medications, vitamin supplements (list all) _________________
  ____
- ❑ Prescriber name and phone number _____________________________________

Other:

Describe any other information that is important to know ___________________________