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CONFIDENTIAL INTAKE ASSESSMENT

The purpose of this assessment is to obtain a comprehensive understanding of your life experience and background. Completing these questions as fully and as accurately as you can, will benefit you through the development of a treatment program suited to your specific needs. Please return this assessment at your first scheduled appointment.

PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES

Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________________ Zip: ____________________

Telephone number(s) you want to be contacted at:

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Social Security #: ____________________ Gender: __________ Age: __________ DOB: ____________________

Place of Birth: ____________________ **EDUCATION**: Highest level achieved: ____________________

College Major or emphasis: ____________________

Additional Special Training: ____________________

Who referred you? ______________________________

Who should we contact in an emergency? Name: ______________________________

Relationship: ____________________ Address: ______________________________

______________________________ Telephone: ____________________

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Sexual history:
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience __________
[ ] age first pregnancy/fatherhood ____
[ ] history of promiscuity age ____ to ___
[ ] history of unsafe sex age ___ to ____
Additional information: ____________________

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: ____________________

Military History:
[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident
____

Cultural History:
· cultural identity (e.g., ethnicity): ____________________
____
·describe any cultural issues that contribute to current problem: ________
____

Leisure History:
·currently active in community/recreational activities? Yes [ ] No [ ]
·formerly active in community/recreational activities? Yes [ ] No [ ]
·how is most of your free time occupied? ____________________
____

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment

[ ] jail/prison ________________________# of times)
total time served: ______________________________
describe last legal difficulty: ___________________
____
____

Significant relationship status (check one):

☐ single (never married)
☐ engaged
☐ married
☐ separated
☐ divorced
☐ remarried
☐ committed relationship
☐ widowed

If engaged, married, separated, divorced or widowed, for how long? ________________________________

Living in a committed relationship? ☐ Yes ☐ No How long have you been together? ________________

Number of previous marriages for you: ______________________ For your spouse: __________________

If married, spouse's name: ______________________ Age: ______ Occupation: ___________________

Is your spouse supportive of seeking counseling? ☐ Yes ☐ No ☐ Unsure ☐ Spouse doesn't know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive): _____________
____

What is your spouse or partner's religious affiliation? ____

CHILDREN: None:_________

Please list your children (including step, adopted, foster) below:

Name	Gender	Age/Yr. of Death	Relationship w/you	Living with whom?

Who else lives with you? ____

SPIRITUAL/RELIGIOUS HISTORY

Check the appropriate box if you want Christian Counseling ☐ Yes ☐ No

Do you regularly attend a church, synagogue, or other religious institution? ☐ Yes ☐ No
If yes, which one? ____

Describe your participation: ____

Childhood religious affiliation, if different from above: _____________________________________

Describe the religious atmosphere you were raised in? ______________________________

How did you feel about your childhood religion? ______________________________

What did your religious training teach you about life?______________________________

What is the role of religion/spirituality in your life?______________________________

____

____

Describe any spiritual experiences that have shaped your life: ______________________________

____

What is your sense of your purpose in life? ______________________________

____

____

CHIEF COMPLAINT (Check All That Apply To You):

- ☐ Depression
- ☐ Low Energy/Fatigue
- ☐ Low Self-esteem
- ☐ Poor Concentration
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Guilt
- ☐ Trouble Sleeping/Sleep Too Much
- ☐ Loss of Appetite/Overeating
- ☐ Grief/Loss
- ☐ Mood Swings
- ☐ Isolation/Social Withdrawal
- ☐ Apathy
- ☐ Stress
- ☐ Anxiety/Panic
- ☐ Feeling that you are not real
- ☐ Feeling that things around you are not real
- ☐ Nightmares
- ☐ Unpleasant thoughts won't go away
- ☐ Anger/Frustration
- ☐ Easily Agitated/Annoyed
- ☐ Impulsive Behavior
- ☐ Argues/Blames Others
- ☐ Alcohol/Drug Abuse
- ☐ Prescription Abuse
- ☐ Laxative/Diuretic Abuse
- ☐ Emotional Abuse Issues
- ☐ Physical Abuse Issues
- ☐ Sexual Abuse Issues
- ☐ Spousal Abuse Issues
- ☐ Fear of going crazy
- ☐ Phobias
- ☐ Racing Thoughts
- ☐ Anorexia/Bulimia
- ☐ Excessive Behaviors (spending, gambling)
- ☐ Obsessions/Compulsions
- ☐ Can't hold onto an idea
- ☐ Delusions
- ☐ See things others don't
- ☐ Hearing Voices
- ☐ Not thinking clearly/confusion
- ☐ Sexual Problems
- ☐ Marital Problems
- ☐ Other Relationship Problems
- ☐ Career/Work problems

PRESENTING PROBLEM/CHIEF COMPLAINT DESCRIPTION

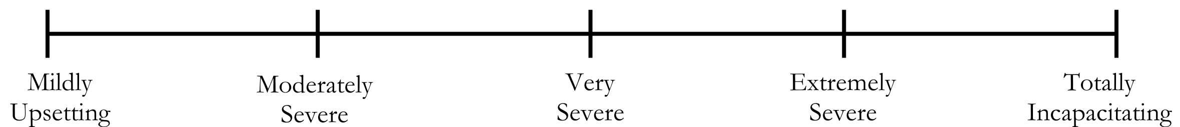
State in your own words the nature of your main problem(s) and a brief history of your complaint(s) from onset to present:

____

____

____

On the scale below please use an "X" to indicate the severity of your problem(s):



Mildly Upsetting | Moderately Severe | Very Severe | Extremely Severe | Totally Incapacitating

A. Were you ever hospitalized because of mental illness? ☐ Yes ☐ No

B. How many times have you been hospitalized? ______________________________

C. When were you first diagnosed with a mental illness? ______________________________

D. Have you previously consulted anyone about your present problem(s)? ☐ Yes ☐ No

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, residential/in-patient care or hospitalizations, please list the names of the therapists, hospitals or programs below:

Therapist's Name/Hospital or Program	Major Issue/Diagnosis	Dates

2. Have you ever attempted suicide or homicide? ☐ Yes ☐ No
   a. If yes, how many times ________________
3. Are you currently feeling suicidal or homicidal? ☐ Yes ☐ No
   a. If yes, do you have a plan? ☐ Yes ☐ No
   b. If you have a plan, please describe: ________________
   ____
   c. Do you have the means to carry out your plan? ☐ Yes ☐ No
   d. If yes, please explain: ________________

MEDICATION COMPLIANCE

A. If you are presently taking psychotropic medication(s) please list each one below:

Name	Dosage	Frequency

B. Do you know your medication schedule? ☐ Yes ☐ No

C. Do you think the medication is helping? ☐ Yes ☐ No

D. Do you experience any side-effects? ☐ Yes ☐ No

If yes, describe symptoms: ________________

MEDICAL HISTORY: Please check below which of the following medical symptoms you have experienced in the **Past (P)** and/or **Currently (C)**:

P	C		P	C		P	C		P	C		P	C	
		Fainting			Constipation			Premenstrual Syndrome			Back Pain			Stroke
		Asthma			Stomach Ailments			Weight Problems			Chest Pain			Heart Disease
		Vomiting			Ulcer			Allergies			Painful Joints			Tuberculosis
		Dizziness			Unusual Bleeding			Diabetes			Head Injury			Birth Defects
		Headaches			Skin Problems			Cancer			Pounding Heart			Trouble Breathing
		Neck Pain			HIV Positive			High Blood Pressure			Jaw/Dental Pain			Chills/Hot Flashes
		Chronic Pain			Hepatitis A/B/C			Thyroid Problems			Unconsciousness			Tingling/Numbness

Please list any other major conditions, illnesses, accidents, surgeries, treatments or hospitalizations you have had and when they occurred? ____

____

Are you currently receiving any medical treatment? ☐ Yes ☐ No
If yes, please describe: ____

Please list any non-psychotropic prescription and over-the-counter medications you are currently taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)

Name of Medication(s)	Dose/Schedule	Reason for Taking

Are you taking these medications according to the doctor's recommendations? ☐ Yes ☐ No
If no, please explain: ____

Date and outcome of last physical exam: ____

What is your height?___________ What is your weight? _______ Describe any regular exercise regimen: _______________

____

FAMILY HISTORY
Please list your father, mother, sisters, brothers, step family relations, or family members who had significant effect on your life (either positive or negative).

Name	Gender	Age/Yr. of Death	Relationship w/you	Describe your relationship with each family member listed (e.g., loving & supportive, argumentative & controlling, etc.)

DESCRIBE YOUR CHILDHOOD FAMILY EXPERIENCE:

[ ] Outstanding home environment
[ ] Normal home environment
[ ] Chaotic home environment
[ ] Witnessed physical/verbal/sexual abuse toward others
[ ] Experienced physical/verbal/sexual abuse from others

1. Were there any special circumstances in your childhood? ____
2. Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? ☐ Yes ☐ No
   a. If yes, please describe: ____
3. Have any of your family members or friends ever attempted or committed suicide? ☐ Yes ☐ No
   a. If yes, please describe: ____

SUBSTANCE ABUSE HISTORY

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other ___________________

Substance use status:
[ ] no history of abuse
[ ] active abuse
[ ] no active abuse/dependence in 1-11 months
[ ] partial abuse/dependence in 1-11 months
[ ] no active abuse/dependence in over 12 months
[ ] partial abuse/dependence in over 12 months

Substances used: (complete all that apply)	**First use age**	**Last useage**	**Current Use (Yes/No)**	**Frequency**	**Amount**
[ ] alcohol	________	________	______	______	______
[ ] amphetamines/speed	________	________	______	______	______
[ ] barbiturates/owners	________	________	______	______	______
[ ] caffeine	________	________	______	______	______
[ ] cocaine	________	________	______	______	______
[ ] crack cocaine	________	________	______	______	______
[ ] hallucinogens (e.g., LSD)	________	________	______	______	______
[ ] inhalants (e.g., glue, gas)	________	________	______	______	______
[ ] marijuana or hashish	________	________	______	______	______
[ ] nicotine/cigarettes	________	________	______	______	______
[ ] PCP	________	________	______	______	______
[ ] prescription__________	________	________	______	______	______
[ ] other______________	________	________	______	______	______

Treatment history:
[ ] outpatient (age[s]_______________)
[ ] inpatient (age[s]_______________)
[ ] 12-step program (age[s]__________)
[ ] stopped on own (age[s]__________)
[ ] other (age[s]_________________

Consequences of substance abuse (check all that apply):
[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other ____

Describe: ____

OCCUPATIONAL DATA

A. What is your current occupation? ______________________________
B. Why did you choose your present occupation? ______________________________
C. How do you feel about your work situation?______________________________
D. Are you considering changing employment? ☐ Yes ☐ No. Why? ______________________________
E. What are your long-term career goals? ______________________________

____

TREATMENT EXPECTATION & GOALS

1. What is there about your present behavior that you would like to change? ______________________________

____

2. How would your life be different if you did not have the difficulties described previously? ______________________________

____

3. In a few words, what do you think therapy is all about? ______________________________

____

4. What do you hope to accomplish from therapy, and how long do you expect therapy to last? ______________________________

____

5. Please add any information not brought up by this questionnaire that may aid your therapist in understanding and helping you (List any additional problems or difficulty here): ______________________________

____

Client's Signature: ______________________________ Date: ______________