# 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.

***General Information*** Today's Date: ____/____/____

Name: ______________________________
(Last) (First) (Middle Initial)

Preferred name: ______________________

Name of Parent/Guardian (if under 18 years):

______________________________
(Last) (First) (Middle Initial)

Birth date: ______/______/______ Age:______ Pronouns:______________
MM DD YYYY (ex. he, she, they)

Home phone: (    )______________ May we leave a message? [ Y ] [ N ]

Cell Phone: (    )______________ May we leave a message? [ Y ] [ N ]

Work Phone: (    )______________ May we leave a message? [ Y ] [ N ]

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

Address:______________________________

City:______________ State:______________ Zip:______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐White/Caucasian ☐African-Am. ☐Asian ☐Latino/Hispanic ☐Native Am. ☐Multi-racial Other:______________

Religion:______________ Cultural Considerations:______________

***Emergency Contact***
Name:________________________ Relationship:________________________

Home Phone: (     )______________ Cell Phone: (     )______________

Permission to call? [ Y ] [ N ] Restrictions?______________________________________

Referred by (if any):
Name:______________________________ Phone: (     )________________________

***Employment***
Employer/School:______________________________

Occupation/Year in School:______________________________

***Current Household***
Does anyone currently reside with you in your home? [ Y ] [ N ]
If yes, provide information below:

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have children? [ Y ] [ N ]
If yes, provide information below:

| Name | Age | Lives at | (Circle one) |
|---|---|---|---|
| | | | Biological/Adopted/Step-child |
| | | | Biological/Adopted/Step-child |
| | | | Biological/Adopted/Step-child |
| | | | Biological/Adopted/Step-child |
| | | | Biological/Adopted/Step-child |

***General Physical & Mental Health Information***
Primary Physician:______________________________________

Address:______________________________________________________________________

Phone: (     )______________________________________

Allergies (if any):______________________________________________________________

Overall, how is your general physical health?________________________________________

How many times per week do you generally exercise?________________________________

Overall, how is your general mental health?______________________________________

Have you previously received any type of mental health services? (Example: psychotherapy, psychiatric services, etc.)
[ Y ] [ N ]
If yes, provide information below:

Name:________________Treatment for:_________________ Duration (mm/yy-mm/yy):__________

Name:________________Treatment for:_________________ Duration (mm/yy-mm/yy):__________

Name:________________Treatment for:_________________ Duration (mm/yy-mm/yy):__________

Have you ever been treated for alcohol or drug abuse? [ Y ] [ N ]
If yes, provide information below:

Name:________________ Location:_________________ Duration (mm/yy-mm/yy):____________

Name:________________ Location:_________________ Duration (mm/yy-mm/yy):____________

Name:________________ Location:_________________ Duration (mm/yy-mm/yy):____________

Have you ever been a victim of physical, sexual, or verbal abuse? [ Y ] [ N ]

Are you currently taking any prescription medications? [ Y ] [ N ]
Please list:_______________________________________

_______________________________________

Have you ever been prescribed psychiatric medication? [ Y ] [ N ]
Please list:_______________________________________

_______________________________________

Current Symptoms (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Anxiety | ☐ Lack of appetite | ☐ Panic attacks | ☐ Crying spells |
| ☐ Depression | ☐ Excess appetite | ☐ Suspiciousness | ☐ Guilt |
| ☐ Hallucinations | ☐ Lack of energy | ☐ Impulsivity | ☐ Libido changes |
| ☐ Sleeping less | ☐ Excess energy | ☐ Fatigue | ☐ Risky activity |
| ☐ Sleeping more | ☐ Irritability | ☐ Loss of interest | ☐ Racing thoughts |

Have you had suicidal thoughts? [ Y ] [ N ]
If yes, how recently?_______________________________________
If yes, how frequently?_______________________________________

***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.

| | (Circle one) | Relationship |
|---|---|---|
| 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 | |
| Suicidal Thoughts | Yes/No | |

***Legal History***

Do you have a history of any legal charges? [ Y ] [ N ]

If yes, please explain:________________________________________________

________________________________________________

Are you currently on probation or parole? [ Y ] [ N ]

Is treatment court ordered? [ Y ] [ N ]

***Additional Information***

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________________________________________ Date: _____/_____/_____

Signature of Client

x________________________________________ Date: _____/_____/_____

Signature of Parent/Guardian