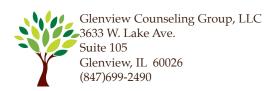


Intake Assessment To be completed by client only

Client's Name:	Date of Birth:						
Age:	Sex: M / F	Marital Status:					
Address:							
City/State:							
Referral Name:							
		Precipitating F	actors				
In general terms, wh	y are you seel	king counseling at	this time:				
Treatment History:							
Outpatient:							
Inpatient:	·						
	Currer	nt or Recent Gen	eral Symptoms				
	(Please circle)						
Appetite Change	Loss	of Interest	Frequent Anger				
Disturbed Sleep			Lying				
Despondent	Illega	Behaviors	Isolation				
Hopeless	Tearfu	ال	Motivation Loss				
Truancy	Sad		Feelings of Guilt				
Damaging Property	Mood	Swings	Physical Complaints				
Bullying/Fighting	Impul	sivity	School Problems				
Cruel to Animals	Increa	ased Energy	Racing Thoughts				
School Anxiety	No Er	nergy	Relationship Problems				
Impaired Social Ability	Poor	Judgement	Restless				
Hyperactive/ADHD	,		Rebellious				
Suicidal Thoughts	Homi	cidal Thoughts	Suicidal Attempts				
Othor:							



Current or Recent Anxiety or OCD Symptoms

(Please Circle)

Restless	Panic Attacks	Obsessions	Unable to Function		
Fears	Paranoid/Suspicious	Worrying	Ruminating		
Cleanliness	Orderliness	Avoiding	Hair Pulling		
Skin Picking Impulses/Tics		Counting	Reassurance Seeking		
Checking	Repeating	Washing	Hoarding		
Thought Spinning	Trauma Flashbacks	Other:			
	Current or F	Recent Other Sy	rmptoms		
Disoriented/Confused	Hallu	cinations	Delusions		
Aggression/Hostility	gression/Hostility Sever		Disorganized Thoughts		
Disorganized Speech	Racir	ng Thoughts	False Beliefs		
Excited Behaviors	Mem	ory Impairment	Wandering		
Other:					
Current Medical Co	nditions & Allergies:				
	Curi	rent Medication	s		
Medication name ar	nd dosage:		Prescribing MD:		
	nd dosage:		Prescribing MD:		
	•		Prescribing MD:		
	•		•		
iviculcation name at	iu uusay e		Prescribing MD:		



Relationship Status

(Please Circle)

Single Married Part Relationship satisfactio	•		wed Other:				
Current Household Please list the names, ages and relationships of the people living in your home:							
Name	Age	Relationship	Comments				
Job title or function:		nt or Recent Employ					
			lities:				
		ent or Recent Educat	tion				
How symptoms have in	terfered with s	chool responsibilities:	Year or grade:				
		Spirituality and Faith					
	_		religion or faith?				
How nave symptoms at	Tected or been	affected by religion of	faith?				
Signed:			Date:				
Witness:			Date:				