Intake Assessment

To be completed by adult client or parent of minor

Client's Name: ________________________________ Date of Birth: ________________________

Age: __________ Sex: M / F Person Filling Out Form: _____________________________

Address: ____

City/State: ____ Zip: ______________________

Referral Name: ____

Precipitating Factors

In general terms, why are you seeking counseling at this time:_____________________________

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Treatment History:

Outpatient:____

Inpatient:____

Current or Recent General Symptoms

(Please circle)

Appetite Change	Loss of Interest	Frequent Anger
Disturbed Sleep	Self Injurious Behavior	Lying
Despondent	Illegal Behaviors	Isolation
Hopeless	Tearful	Motivation Loss
Truancy	Sad	Feelings of Guilt
Damaging Property	Mood Swings	Physical Complaints
Bullying/Fighting	Impulsivity	School Problems
Cruel to Animals	Increased Energy	Racing Thoughts
School Anxiety	No Energy	Relationship Problems
Impaired Social Ability	Poor Judgement	Restless
Hyperactive/ADHD	School Refusal	Rebellious
Suicidal Thoughts	Homicidal Thoughts	Suicidal Attempts

Other: ____

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 Recent Other Symptoms

Disoriented/Confused	Hallucinations	Delusions
Aggression/Hostility	Severe Paranoia	Disorganized Thoughts
Disorganized Speech	Racing Thoughts	False Beliefs
Excited Behaviors	Memory Impairment	Wandering

Other: ____

Any current or past eating disorder behaviors: ______________________

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Any current or past substance abuse behaviors: ______________________

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Current Withdrawal Symptoms: ______________________________

Current Medical Conditions & Allergies: ______________________

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Current Medications

Medication name and dosage: ______________ Prescribing MD: __________

Medication name and dosage: ______________ Prescribing MD: __________

Medication name and dosage: ______________ Prescribing MD: __________

Medication name and dosage: ______________ Prescribing MD: __________

Relationship Status

(Please Circle)

Single Married Partnered Separated Divorced Widowed Other: ___________________

Relationship satisfaction: ____

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Current Household

Please list the names, ages and relationships of the people living in your home:

Name	Age	Relationship	Comments

Current or Recent Employment

Job title or function: ________________________________ Company: ________________

How symptoms have interfered with employment responsibilities: ________________________

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Current or Recent Education

Name of school: ________________________________ Year or grade: ________________

How symptoms have interfered with school responsibilities: _____________________________

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Spirituality and Faith

Do you identify with a religion or faith? Y / N If so, which religion or faith? ______________

How have symptoms affected or been affected by religion or faith? _______________________

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Client Signature: ___________________________________ Date: __________________

Clinician Signature: _________________________________ Date: __________________