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INTAKE EVALUATION

Client Information

Legal Name:_____ Age:_____ Date of Birth:___/___/___ Today's Date:___/___/___

How may I address you?:_____Referred to therapy by:_____

May I have your permission to acknowledge and thank this person for the referral? Yes No Maybe (Let me think about it)

Home Address:_____ City:_____ State:_____ Zip code:_____

Home Telephone:_____ Work Telephone:_____ Cell:_____

Messages: No Yes Messages: No Yes Messages: No Yes

Preferred Contact Telephone:_____ Email Address:_____ May I email you: No Yes

Emergency Contact:_____ Relationship:_____ Telephone:_____

Who is financially responsible for your treatment: Self Other (please specify): _____

Health Insurance: No Yes Do you plan to utilize insurance benefits for treatment: No Yes

Name of Insurance Co:_____ Your Insurance ID #:_____ Group #:_____

Demographic Information:

Gender:_____ Race/ethnicity: _____ Sexual Orientation:_____

Relationship Status (please circle all that apply): Single / Married / Partnered / Cohabitating / Engaged / Seeking Partner / Separated / Divorced / Remarried / Widow / Widower / Other:_____

Others living in your home:

	Name	Age	Relationship		Name	Age	Relationship
1.				3.			
2.				4.			

Others:_____

Education/highest grade or degree completed:_____ Currently Employed: Yes No

Occupation:_____ Employer/School:_____

Military Service: No Yes Dates of Service: _____ If yes, did you serve in a combat zone: Yes No

Client or Authorized Person's Signature: I authorize the release of any medical or other information necessary to processes a claim/payment. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signature: _____ Date: _____

NAME:_____ **Date of Birth:**_____

Current Concerns

Please state the reason(s) and concern(s) for which you are seeking therapy:_____
_____
_____

What made you decide to seek therapy at this specific time:_____
_____
_____

How long have you struggled with your presenting concern(s):_____

What are your hopes and goals for therapy:_____
_____
_____

What are some of the qualities that you or others value about yourself:_____
_____

How do you practice self-care:_____

Who or what do you consider to be sources of support in your life:_____
_____

Treatment & Health History

Have you ever participated in psychotherapy/counseling: No Yes If yes, with whom and when:_____
_____

Have you ever been treated with medication and/or supplements for mental health concerns: No Yes
If yes, please list the medication/supplements and related time period(s):_____
_____

Is there any know family history of emotional/mental health difficulties or addiction problems (e.g., parents, siblings, extended family): No Yes If yes, please describe the relationship and nature of their difficulty: _____
_____

Current physical/medical health issues:_____

Any history of major injuries, accidents, illnesses, hospital or ER visits: No Yes If yes, please specify:_____
_____

Are you currently utilizing ANY medications and/or supplements: No Yes If yes, please specify the medication & dosage; and also the condition for which you take it:
_____

Medication allergies:_____ Other allergies:_____

Primary care provider:_____Telephone:_____

May I contact your primary care provider to coordinate care? No Yes Maybe (I'd like to think about it)

NAME:_____ Date of Birth:_____

Please circle any of the following symptoms or issues that have been a problem or concern for you *during the past two weeks*.

If certain issues have been problematic in the past, but may no longer be a significant problem, please note "prior or past" next to it. Also, please feel free to elaborate next to any item or on an additional sheet of paper.

Anxiety
Frequent worry
Racing thoughts
Intrusive thoughts
Intrusive images/flashbacks
Phobia(s)/fear: _____
Panic attacks
Feelings of doom
Difficulty Concentrating
Obsessive thoughts
Compulsive behaviors
Social discomfort

Depression
Sadness
Weepy/tearful
Mood swings
Excessive energy
Lack of energy
Low self-esteem
Self-berating
Guilt
Lack of confidence
Loneliness

Sleep Difficulties:
falling asleep -
waking up excessively -
poor sleep - waking up too early -
difficulty getting out of bed - nightmares
other:_____

Hopelessness
Helplessness
Thoughts of death/dying
Anger
Irritability

Sexual difficulties
Appetite changes
Weight
Body image
Impulse control problems

Thoughts of self-harm: past / present
Acting on self-harm past / present
Thought of harming others: past / present
Acting on thoughts of harming others past / present

Hallucinations
Perceptual disturbances
Paranoia

Involved in a traumatic event
Witnessed traumatic event
Victim of crime
Legal problems past/present

Emotional abuse: past / present
Physical abuse: past / present
Sexual abuse: past / present
Domestic violence: past / present
Other Symptoms/issues:_____

About often do you use alcohol:_____
About how much do you typically drink in a 24hr period:_____
Was there a time when you drank more regularly and/or heavily: No Yes
Has drinking ever had a negative impact on your life, relationships or responsibilities: No Yes
Do you have any concerns about your alcohol use: No Yes Have others expressed concern: No Yes
Would you like to change your relationship with alcohol: No Yes Maybe
Do you use cannabis in any form: No Yes If yes, about how often:_____ Quantity:_____
Do you use any nicotine products: No Yes If yes, about how often:_____ Quantity:_____
Do you use caffeine: No Yes About how much:_____ About how often:_____
About how often do you use recreational or other drugs:_____
About how often do you gamble in any form:_____
Do you or others have concerns about addiction problems (e.g., internet, pornography, sex spending, gambling) No Yes

Please provide any additional information on the back or on an additional sheet of paper that may be helpful for me to better understanding you and your concerns: