**Intake Assessment**

Today’s Date: Click or tap to enter a date. Email:

**Personal Information:**

Name:  Social Security: 

Age:  Sex:  Date of Birth: Race/Ethnic Group: 

Home Phone:  Cell Phone:  Address: 

**Marital Status:** (please check one) Never Married: Married: Divorced: Widowed: Separated

City: State: Zip:  Message Ph #: 

**Insurance Information: **

Number of Children:  Their Ages: 

Emergency Contact Person: 

Click here to enter text.

**Education / Employment Information** Last grade completed in school:

 Describe your education (special training, etc.): 

Are you employed now? Yes No Present Occupation/Company:

Main occupation during past 5 years: 

How much have you worked during the past two years? 

**Spiritual History:**  Religious Affiliation: 

Do you currently attend a place of worship? 

List those that support you most spiritually:

**General Information:** How did you hear about us? 

Problems you want help with: 

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, or etc.) 

Describe your living situation: 

 Did anyone in your family die before you were 18 years old? **** Yes **** No Who / Your age? 

When were you last examined by a physician/His or her name/telephone number?

**List any major health/psychological problems for which you have received treatment and when**: 

Do you or your family members currently have or have ever had any of the following: (Please check all that apply)

**Self** **Family**

** ** HEART PROBLEMS

** ** CANCER

** ** NERVOUS BREAKDOWN

** ** STROKE

** ** CHRONIC ILLNESS

** ** ALCOHOL OR DRUG ABUSE

** ** LEGAL PROBLEMS

** ** LEARNING DISABILITY

** ** DEPRESSION

** ** OTHER

**List any medications you are now taking (prescription and non-prescription):** 

**Abuse History:**

Have you been abused or assaulted? **Y**ES ****NO **D**ON’T REMEMBER



****YES ****NO **** DON’T REMEMBER Did you witness abuse between your parents? 

**** YES ****NO ****DON’T REMEMBER Did you witness abuse between parent and child? 

****YES **** NO ****DON’T REMEMBER Have you ever received psychiatric or psychological help or counseling of any kind before? If you have, please explain: 

 List everyone currently living in your home, including family and other: 

**Please check any of the following strengths you have:**

****CONFIDENT **** DEPENDABLE ****DECISIVE **** PATIENT

****HARD WORKER ****SENSITIVE ****RESPONSIBLE ****  OTHER

****ORGANIZED **** LOGICAL ****UNDERSTANDING **** GRACIOUS

****SYMPATHETIC **** LOYAL ****SENSE OF HUMOR **** GOOD LISTENER

**Please use the chart below to describe your use of drugs. Complete the “yes” or “no” lines for each drug listed, and if “yes”, answer the remaining questions on the line.**

**No, I Never Used**

**Yes, I Used If yes, age at first use**

**When using, frequency of use (daily, weekly, etc.)**

**How long since last used?**

**Yes No Never Used**

Tobacco    

Alcohol    

Marijuana/Hashish    

Cocaine    

Crack    

Crank    

Methamphetamine    

Hallucinogens    

(LSD, Mushrooms, Mescaline, etc.)

Coffee    

Other    

**Legal History:** 

**Military History:** 

|  |  |
| --- | --- |
| **Problem Checklist (Check all that apply):** | |
| **Eating Pattern:** | None Bulimia Increased Appetite Anorexia Decreased Appetite |
| **Depressed Mood:** | None Feeling Worthless Crying Spells  Insomnia Low Energy Lost of Interest Irritability Social Withdrawals Suicidal Thoughts Suicidal Ideations Suicidal Plan |
| **Sleep Problems:** | None Difficulty Staying Asleep Erratic Sleep Patterns Sleeping Excessively Difficulty Falling Asleep |
| **Anger/Aggression:** | None Physical Conflict Easily Angered Verbal Outburst Un-forgiveness Homicidal Thoughts  Homicidal Ideations  Homicidal Plan |
| **Mood Swings:** | Pressured Speech Decreased Need of Sleep Hyper Social Elevated Mood Rapid Ideas Poor Judgement Grandiosity Motor Agitation Distractibility |
| **Anxiety:** | None Restlessness Excessive Worry Muscle Tension Easily Fatigued Panic Attacks Increased Stress |
| **Traumatic Stress:** | None Constant Family Conflict Major Illness or Trauma to Family Member Recent Moves or Change of Custody Mental Illness and/or Substance Abuse in Family Death or Loss of Significant Other |
| **Inattentive/Impulsivity:** | None Daydreaming Difficulty Focusing Difficulty Concentrating |
| **Cont.**  **Inattentive/Impulsivity:** | None Fidgety Excessive Talking Distractibility Poor Concentration Impulsive Acts Hyperactive Poor Judgement Risk Taking Behavior |
| **Conduct Issues:** | None Serious Rule Violation Lack of Remorse Aggression to people Destruction of Property Theft Aggression to Animals Deceitfulness/Lying |
| **Other Behaviors:** | None Age Inappropriate Sex Fire Setting Multiple Sex Partners Sexual Perpetrator Bed Wetting |
| **Addictive Behaviors:** | None Compulsive Shopping Compulsive Eating Compulsive Gambling Compulsive Sexual Bx Compulsive Substance Abuse  Compulsive Social Media |
| **Psychosis:** | None Disorganized Speech Visual Hallucinations Auditory Hallucinations Paranoia |
| **Educational:** | None Drop-Out Learning Disabilities Truancy Resources/Special Ed |
| **Parental Issues:** | None Conflictual Relationship Parent Incarcerated No Relationship with Mom No Relationship with Dad |
| **Relationship Issues:** | None Peer Problems No Friends Marital Problems Few Friends Sibling Conflicts Divorce Separation |
| **Medical Necessity Indicators (Check all identified psychiatric or behavioral areas of impairment)** | |
| **Occupational/Work Problems**  **Social/Relationship Problems:**  **Family Issues:** Choose an item.  **Scholastic/School Problems:**  **Self-Care Problems:**  **Stressful Life Circumstances:**  **Self-harmful Behaviors:**  **Persistent DSM-V Illnesses:** | |
| **Current Mental Status (Check all that apply):** | |
| **General Appearance:** Slumped**,** Muscular Choose an item.  **Behavioral/Motor Activity:** Choose an item.Choose an item.Choose an item.  **Mood/Affect:** Choose an item.Choose an item.  **Speech:** Choose an item.Choose an item.  **Thought Process:** Choose an item.Choose an item.  **Perception:** Choose an item.  **Orientation:** To Person, To Place, To Situation, To Time  **Memory:** Recent Intact (can repeat 3 digits), Remote Intact (Can provide history)Choose an item.  **Insight/Judgment into Illness/Life Situation:** Choose an item.  **Intelligence Estimate:** Choose an item.  **Mental Status Summary:** Choose an item.  **Current Risk of Harm:** Choose an item.  **Suicidal/Homicidal safety Plan:** Choose an item. | |
| **Comprehensive Intake Assessment** | |
| **Narrative Response: LPC and client met at 1415 S. University Avenue Little Rock, AR 72204.**  Client presents with history, presenting problems, and concerns after client was referred for services by . Client reports | |



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| --- |
| **DSM Diagnosis**  **Diagnostic Category 1:** Choose an item.  **Diagnostic Category 2:** Choose an item.  **Diagnostic Category 3:** Choose an item.  **Medical Diagnoses:**  **Social Elements Impacting Diagnosis:** Primary, Social, Environmental |

|  |
| --- |
| **Treatment Recommendation:**  It is recommended that the client receive outpatient mental health services in the form of clinical evaluation, individual, family therapy and medication management if clinically indicated. Projected length of treatment is 6-12months. The focus of treatment will include assisting the client in identifying and expressing thoughts and feelings, identifying positive coping techniques, identifying problem solving techniques, decision making, and impulse control.  **Focus of Goals and Recommendations:**  Treatment will focus on client developing positive coping skills, problems solving skills, good decision making, and communicating feelings and needs to others in a healthy/respectful manner. Also focus on identifying positive, negative behaviors and their consequences. |



**Therapist’s Signature/Degree**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Click or tap to enter a date.



**Client/Responsible Party Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Click or tap to enter a date.