

# INTAKE EVALUATION

## Part I: To be completed by client

### 1. IDENTIFYING INFORMATION

Client's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Partner's Name (if being seen as a couple): \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone (s): \_\_\_\_\_  
(home) Client (work/cell) Email address

May we leave messages for you at home? Yes or No: \_\_\_\_\_

May we leave messages on your cell phone? Yes or No: \_\_\_\_\_

May we leave messages for you at work? Yes or No: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Partner Status: \_\_\_\_\_

Others living in the home: \_\_\_\_\_,  
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

\_\_\_\_\_, \_\_\_\_\_,  
(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client)

Education: Self: \_\_\_\_\_ Partner: \_\_\_\_\_

Occupation: Self: \_\_\_\_\_ Partner: \_\_\_\_\_

Client's Employer: \_\_\_\_\_ Social Security (ID) Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

**2. PRESENTING PROBLEMS**

Describe the problem that brought you here today:

Check any of the symptoms that you are having:			(This space reserved for additional comments by clinician)	
Depression	<input type="checkbox"/>	Feeling hopeless		<input type="checkbox"/>
Extreme sadness	<input type="checkbox"/>	Feeling tearful		<input type="checkbox"/>
Trouble concentrating	<input type="checkbox"/>	Change in sleeping habits		<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	Lack of energy		<input type="checkbox"/>
Change in eating habits	<input type="checkbox"/>	Weight changes		<input type="checkbox"/>
Feeling of extreme happiness	<input type="checkbox"/>	Change in sexual interest or function		<input type="checkbox"/>
Trouble performing your job	<input type="checkbox"/>	Problems getting along with friends or families		<input type="checkbox"/>
Lack of enjoyment of usual activities	<input type="checkbox"/>	Feeling stressed		<input type="checkbox"/>
Self-esteem problem	<input type="checkbox"/>	Easily irritated		<input type="checkbox"/>
Perfectionism	<input type="checkbox"/>	Feeling guilty		<input type="checkbox"/>
Obsessions or compulsions	<input type="checkbox"/>	Feeling nervous		<input type="checkbox"/>
Feeling fearful	<input type="checkbox"/>	Sudden feelings of panic		<input type="checkbox"/>
Physical complaints of pain	<input type="checkbox"/>	Muscle tension		<input type="checkbox"/>
Problems with anger	<input type="checkbox"/>	Acting violently		<input type="checkbox"/>
Thoughts about hurting yourself or others	<input type="checkbox"/>	Thoughts about killing yourself or others	<input type="checkbox"/>	

**3. HAVE YOU EVER BEEN IN COUNSELING BEFORE?**

Yes  No

If you have been in counseling before, please describe it below. Start with most recent time first.

A.	When did you have counseling	Date(s):
	Who did you see?	Name:
Explain what happened:		
B.	When did you have counseling?	Date(s):
	Who did you see?	Name:
Explain what happened:		
C.	Have you ever been hospitalized for mental health concerns?	Date(s):
	Facility:	Length of Stay:
D.	Have you ever or are you currently engaging in self harm?	Currently: _____ Past: _____
E.	Have you ever or are you currently contemplating suicide?	Currently: _____ Past: _____
Have you ever attempted suicide? If yes, please list date(s), method(s), and your age at time of attempt		
F.	Have you ever or are you currently contemplating harming another person?	Currently: _____ Past: _____
G.	Have you ever or are you currently a victim of abuse?	Currently: _____ Past: _____

**4. Family History of Mental Health Concerns**

Yes No

If you answered yes, please describe what you know about your family's history of mental health problems and/or treatment below

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**5. MEDICAL INFORMATION**

Have you seen a doctor within the past year?    Yes <input type="checkbox"/> No <input type="checkbox"/>
Why have you seen a doctor?
Who is your doctor? <span style="float: right;">Phone:</span>
Are you taking any kind of medicine (prescription or over-the-counter)?    Yes <input type="checkbox"/> No <input type="checkbox"/>
Please list the medications that you are taking:
Do you have allergies to anything?    Yes <input type="checkbox"/> No <input type="checkbox"/>

**6. SUBSTANCE USE HISTORY**

Do you use/have you used tobacco (any form)?	Current	Past	No
Do you use/have you used alcohol?	Current	Past	No
Do you use/have you used caffeine (any form, including cola drinks)?	Current	Past	No
Do you/have you used recreational drugs?	Current	Past	No
Are you currently or have you in the past accessed substance abuse treatment?	Current	Past	No

**7. Please mark all of the items below that apply, and feel free to add any others at the bottom under “any other concerns or issues.” You may add a note or details in the space next to the concern checked.**

- I have no problems or concerns bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly)
- Alcohol use
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, choices
- Childhood issues (your own childhood)
- Children, child management, child care, parenting
- Confusion
- Compulsions
- Custody of Children

- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, sadness, frequent crying
- Divorce, separation
- Drug use/abuse—prescriptions, over the counter medications, street drugs
- Eating problems—overeating, under-eating, appetite, vomiting
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches or other kinds of pains
- Health, illness, medical concerns, physical problems
- Inferiority Feelings
- Interpersonal Conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Relationship conflict, distance/coldness, infidelity/affairs
- Memory problems
- Mood Swings
- Motivations problems
- Nervousness, tension
- Obsessions/Compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness

- Relationship problems
- School Problems
- Self-Centeredness
- Self-Esteem
- Self neglect, poor self care
- Sexual issues
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Social anxiety, extreme shyness
- Stress, relaxation, stress management, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Withdrawal, isolating
- Work problems, employment, overworking, can't keep a job

Any other concerns or issues:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Please look back over the concerns you have checked and choose the one (s) that you most want help with. It is:** \_\_\_\_\_

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law without permission.