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: _____

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: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

_____ Date: _____

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2. PRESENTING PROBLEMS

Describe the problem that brought you here today:

Check any of the symptoms that you are having:

Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feeling of extreme happiness		Change in sexual interest or function	
Trouble performing your job		Problems getting along with friends or families	
Lack of enjoyment of usual activities		Feeling stressed	
Self-esteem problem		Easily irritated	
Perfectionism		Feeling guilty	
Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts about hurting yourself or others		Thoughts about killing yourself or others	

(This space reserved for additional comments by clinician)

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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 ☐ No ☐
Why have you seen a doctor?
Who is your doctor? Phone:
Are you taking any kind of medicine (prescription or over-the-counter)? Yes ☐ No ☐
Please list the medications that you are taking:
Do you have allergies to anything? Yes ☐ No ☐

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

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☐ 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.