INTAKE ASSESSMENT-INITIAL PAPERWORK

Date: _____

Name: _____DOB: _____Age: _____

Address: _____

Telephone – Home: _____Work: _____Cell: _____

Emergency Contact/Tele #: _____

Name of Employer: _____Position: _____

Name & Ages of Children, including Stepchildren _____
_____
_____

List Prior Arrests/Convictions and Approximate Dates, Any DUI's? _____
_____
_____

Briefly, what problems or issues led you to seek therapy? _____
_____
_____
_____
_____

Is there a Family History of Domestic Violence? Child Abuse? Please explain. _____
_____
_____

Relevant Cultural or Religious Issues? _____
_____

Any Depressive Symptoms? Please check below:

__Problem Sleeping __Problems with Appetite __Problems with Concentration or Memory
__Social Withdrawal __Crying Spells/Tearful __ Fatigue __Lack of Energy

Please describe the severity and frequency, of these symptoms. When did the symptoms begin? Do you have a history of depression? _____
_____

Is there a family history of depression or anxiety? Any other emotional problems in the family?
_____
_____

Symptoms of Anxiety:

Do you currently experience anxiety or panic attacks? Have you previously? _____

_____

Danger to Self:

If you had suicidal thoughts or plans, is there a means and time frame for the suicide?

_____

_____

Previous suicide attempts?_____

_____

What prevents you from harming yourself? _____

_____

_____

Do you have any of the following: chronic pain, access to pain medication, serious medical conditions, severe financial stress, conflicted divorce/custody battle, chemical dependency, recent loss of job, eviction, etc. – please explain. _____

_____

_____

Do you or have you intentionally injured yourself, e.g. cutting or burning yourself? _____

_____

_____

Danger to Others:

Any thoughts currently of harming someone else? _____

_____

Previous Physical Assaults? _____

_____

What prevents you from harming the other person? _____

_____

_____

Are you going through a conflicted divorce/custody battle, a recent loss of job, or an eviction? _____

Do you own or have access to guns? _____

_____

Medical History:

Any medical problems? _____
_____
Any allergies, including allergies to medication? _____

Currently under a doctor's care? _____Yes _____No

Medications (including purpose of medication, dosage, name of person prescribing the medication, length of time on meds, etc.):
_____
_____
_____

Currently on Disability or Worker's Compensation? _____
_____

Any prior head injuries (including childhood)? _____
_____

Is there a family history of psychiatric problems? _____
_____

Is there a family history of substance abuse? _____
_____

Substance Abuse:

Describe your current use of alcohol and/or drugs (frequency, type of alcohol/drug consumed, use socially or in isolation). Also, influence of (prior) alcohol/drug use on your behavior. _____
_____
_____

Have you ever been arrested because of alcohol/drug use? _____
_____
_____

Have you ever received help, e.g. 12 Step groups, detox, rehab, etc. for alcohol/drug use?
_____
_____

Any usage of steroids?_____
_____

Any usage of herbs, natural supplements?_____
_____

Any concerns about your partner's use of alcohol/drugs? _____
_____

Military Background:

Have you ever served in the military? Combat or non-combat? Honorable discharge?
_____
_____

Educational Background (Highest grade completed, any learning disabilities, ADHD/ADD): _____
_____

Describe any financial problems: _____
_____
_____

Are you satisfied with your current job? If not, please explain: _____
_____

Is the Department of Children's and Family Services involved with you or your family in any way? _____

Has there ever been a child abuse report made against you or your partner? _____
_____
_____

Any prior psychotherapy? Prior psychiatric care? When, with whom and why? _____
_____
_____

Are you currently involved in any lawsuits? Have you previously been involved in any lawsuits? _____
_____

Is there anything else I should know about you that I have not asked? _____
_____
_____

Thank you for completing this Intake Assessment form as completely and candidly as possible. If you remember any additional information as we work together in treatment, please let me know as soon as possible.