INTAKE ASSESSMENT
ADULT

DATE:_______

Client Name:__________________________ Date of Birth:_______ Social Security Number:______________________

Address:____ Phone: _______________________________

Cell Phone:___________________________ Email:_________________________________

Insurance Provider:_______________________________ Name of Insured:_________________ DOB:______________

Insured Subscriber ID:__________________________________ Group/Policy Number:__________________________

Presenting reason(s) for seeking services: (check any that apply)

__Anger management __Anxiety __Addictive behaviors __Alcohol/drugs
__Coping __Depression __Eating disorder __Fear/Phobias
__Mental confusion __Sexual concerns __Sleeping problems __Other (please specify)
Comment:____

Desired outcome or expectations of treatment (changes you would like to make, how we can help)?

____
____

Please list any people, organizations or resources you feel can/have/will help you achieve your goal(s):

____
____

Please list any potential barriers to achieving your goal(s): ____

Family History

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Comments:

Parental Information

__Parents legally married __Mother remarried: Number of times_____
__Parents have ever been separated __Father remarried: Number of times_____
__Parents ever divorced
Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.): ____

Significant Others

(brothers, sisters, grandparents, step-relatives, half-relatives, etc. Please specify relationship)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No

Comments:

Marital Status

	Yes	If yes, length of time	Describe current relationship (if applicable)
Single			
Unmarried, living together			
Legally married			
Separated			
Divorce in progress			
Divorced			
Annulment			
Widowed			
Total number of marriages			

Comments:

Comments:

Development

Are there special, unusual or traumatic circumstances that affected your development? __No __Yes
If yes, please describe: ____
Is there a history of child abuse? __Sexual __Physical __Verbal. Abuse was as __Victim __Perpetrator
If yes, please describe: ____
Other childhood issues: __Neglect __Inadequate nutrition __Other (specify)____________________
Comments re childhood development: ____

Comments:

Social Relationships

Check how you generally get along with other people: (check all which apply)
__Affectionate __Aggressive __Avoidant __Fight/Argue often __Follower
__Friendly __Leader __Outgoing __Shy/Withdrawn __Submissive
__Other
(specify)____
____
Sexual orientation: __________ Comments: ____
Sexual dysfunctions? __No __Yes (describe): ____

Comments:

Religion

How important to you are spiritual matters? __ Not __ Little __ Moderate __ Much
Are you affiliated with a spiritual or religious group? __ Yes __ No
If Yes, describe: ____
Were you raised within a spiritual or religious group? __ Yes __ No
If Yes, describe: ____
Would you like your spiritual/religious beliefs incorporated into the counseling? __ Yes __ No
If Yes, describe: ____

Comments:

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ____
Are you experiencing any problems due to cultural or ethnic issues? __ Yes __ No
If Yes, describe: ____
Would you like your cultural/ethnic practices incorporated into the counseling? __ Yes __ No
If Yes, describe: ____

Comments:

Medical History

Present Physical Condition: (Include general health and any current medical treatment.) ____________________

____

Person to contact in case of emergency: Name: ______________________ Phone: ___________________

Please list any known allergies:____

Past Medical Condition: (List any significant injuries, illnesses or medical conditions for which you have been under medical care). ____

Please list all medications you are currently taking

Medication	Dosage	Prescribed by

Comments:

Counseling/Prior Treatment History

Information about client, past and present

	Yes	No	When	Where	Overall reaction to treatment
Counseling					
Psychiatric treatment					
Suicidal thoughts or attempts					
Drug/alcohol treatment					
Hospitalizations					
Self-help groups *					
Other					

*(for example, AA, Al-Anon, NA, Overeaters Anonymous, etc.)

Are there members of your family who have or have had mental health concerns or treatment?_______________

____

Comments:

Substance Abuse History

Personal substance use, past and present

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Cocaine/Crack								
Marijuana								
Caffeine								
Nicotine								
Other drugs								

Are there members of your family who have or have had a substance abuse problem?______________________

____

Comments:

Education

Fill in all that apply

	Number of years	Currently enrolled		Graduated		Major
		Yes	No	Yes	No	
High school grad/GED						
Vocational						
College						
Graduate						
Other training						

Special circumstances (e.g. learning disabilities, gifted, etc.): ____

Comments:

Employment

Please list your past 3 jobs, beginning with your present one

Employer	Position	Length of Time	Reason for Leaving

Currently:

FT	PT	Temp	Laid-off	Disabled	Retired	Social Security	Student	Other (describe):

Comments:

Military

Branch	Date drafted	Date enlisted	Combat experience		Date of discharge	Rank at discharge	Type of Discharge
			Yes	No			

Comments:

Legal

Current status

Charge	Type			Court	Hearing or trial date
	Traffic	Civil	Criminal		

Are you presently on probation or parole? __ No __ Yes (please describe):________________________________

Past legal history

	No	Yes	If yes, please explain:
Traffic violations			
DWI, DUI, etc.			
Civil involvement			
Criminal involvement			
Other			

Comments:

Therapist signature _________________________________ Date reviewed with client _______________