

CLINICAL INTAKE ASSESSMENT

Client Name: _____

Date: ____ / ____ / ____

Parent/Guardian Name (if under 18):

Address:

_____ street

_____ city

_____ state

_____ zip

Marital Status:

- Never Married Domestic Partnership
 Married Divorced
 Separated Widowed

Date of Birth: _____

Age: _____

Race/Ethnicity: _____

Phone numbers:

Home: _____ (Message: yes/no) Work: _____ (Message: yes/no)

Cell: _____ (Message: yes/no Text: yes/no)

Email Address: _____ Can I email you? yes/no

Emergency Contact:

(REQUIRED) name relationship phone

Insurance/EAP Provider: _____

EAP Auth Number: _____

Subscriber ID Number: _____

Group#: _____



Presenting Problem:

How Is This Problem is Affecting Daily Life:

What Would You Like to Accomplish in Therapy:

Situational/Stress Factors: (Greater stress than usual in the past two years):

Yes	No		Yes	No	
___	___	Death	___	___	Serious Illness
___	___	Job Loss	___	___	Disability
___	___	Moving	___	___	Marriage
___	___	Divorce	___	___	Finances
___	___	Other: _____	___	___	Other: _____

Depressive Symptoms Not present Present

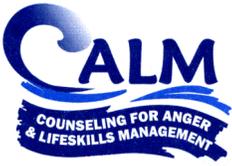
- Depressed Mood
- Diminished interest/pleasure (nearly every day for at least 2 weeks)

And 4 or more of the following nearly everyday:

- Decreased/increased appetite
- Difficulty concentrating/ Difficulty Making Decisions
- Insomnia/hypersomnia
- Recurrent thoughts of death
- Fatigue or loss of energy
- Feelings of worthlessness or excessive/inappropriate guilt

Previous Counseling - yes/no

When? _____ Was it helpful? _____



Living with you:

Name	Age	Gender	Relationship
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

#of marriages: _____

current relationship satisfaction, on a scale of 1-10 _____

of children-names/ages

Current Employment Status/School, Length of time _____

On a scale of 1-10, how would you rate your job satisfaction? _____

Why? _____

Highest Education Level: _____

Current Prescription Medications: yes/no (please continue on back if necessary)

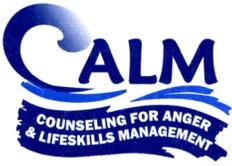
Name - condition prescribed for	dosage/frequency	length of time on med

Name of MD/Psychiatrist: _____

Contact #: _____

Any Previous Diagnosis:

Have you ever been suicidal? yes/no If yes, please detail date (s)



Have you ever attempted suicide? yes/no If yes, please detail method, and any help received

Have you ever been in the hospital for mental health concerns? yes/no If yes, give dates, name of hospital and length of stay.

Currently Feeling Hopeless/Helpless: yes/no

Current feeling suicidal? yes/no

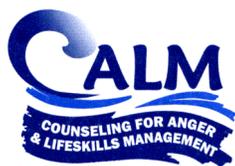
Do you have any religious/spiritual involvement? yes/no - please specify:

What are some of your strengths? Things about you that have helped you through the years?

What are some of your weaknesses? Things about you that have held you back through the years?

Family History (addiction - mental/physical illness - suicide)

Alcohol/Drugs:



Abuse Physical:

Sexual:

Emotional:

Domestic Violence:

Arrests

Medical History/Concerns:

THERAPIST USE ONLY

MENTAL STATUS EXAM SECTION

APPEARANCE	n/a - ok	slight	mod	severe
Unkempt, disheveled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clothing: dirty, atypical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AFFECT	n/a - ok	slight	mod	severe
Inappropriate to thought	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased lability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Odd phys. characteristics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blunted, dull, flat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Euphoria, elation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appears unhealthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger, hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POSTURE					Depression, sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slumped	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>