<u>Intake Assessment Form</u>

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Please note that all information in this form is kept confidential per our services contract.

Client Information

Date:_______________

Name:(First)______________________________(Last)___________________________________

DOB: ________________   Sex: M/F   Age:__________

Address:____

email Address:____

Phone Number:____
It is okay to leave a message at this number (circle one):   Yes   No
It is okay to text this number (circle one):   Yes   No

Alternate Number:____
It is okay to leave a message at this number (circle one):   Yes   No
It is okay to text this number (circle one):   Yes   No

How did you hear about me? ____

Emergency Contact Information
Please note, I will only contact this person in the event of an emergency and will always inform you if I do so.

Name:____

Phone Number:____

Alternate Number:____

About You

Preferred Language(s):____

Hobbies/Interests:____

Reason for contacting me about starting therapy:
____
____

Goals you want to accomplish in working together:

Family History

Currently in a significant romantic relationship? Yes No

Significant prior relationship (divorced, widowed, etc.)? Yes No

Number of children and ages (if applicable):

Dependent adults living with you (if applicable): Yes No

If yes, list relationship:

Who currently lives in your home (list all that apply)?

Pets? Yes No

If yes, list name and type (dog, cat, etc.):

Employment/Education History

Job Title: Current Employer:

Employment concerns (if applicable):

Degree (if applicable):

Current level in school (if applicable):

Educational concerns (if applicable):

Medical History

Primary Care Physician:

Date of most recent physical exam:______________________________

Current medications taken on a regular basis:

____

____

Please list any current medical problems (thyroid disorder, cancer, etc.):

____

____

____

____

Please list any significant medical history (cancer, accidents, surgeries, etc.):

____

____

____

____

Please list any accommodations needed (wheelchair access, etc.):

____

Mental Health Treatment History

Have you been in therapy before? Yes No

If yes, when and for how long? ______________________________

Previous therapist(s) name(s):______________________________

Reasons for previous therapy:______________________________

____

____

Substance Use History

Please list any *current* substance use (alcohol, cigarettes, marijuana, etc.):

____

____

____

____

Frequency of use for above substances listed: Daily Weekly Monthly

Please list any *prior* substance use (alcohol, cigarettes, marijuana, etc.):

____

____

Are you currently in a substance abuse program or support group (circle one)?

Yes No

Have you previously been a member of a substance abuse program or support group (circle one)?

Yes No

Other

Religious/Spiritual Identification:

Healthy Habits/Coping Styles

Have you ever been arrested? Yes No

If yes, please describe charges and outcome:

Do you currently have an assigned probation officer *and/or* social worker for any reason?

Yes No

If yes, please list name:

Please list any other information not listed on this form that you feel is pertinent to my working with you: