Intake Form

Client name____ Date of birth________________

Address:____

Phone Number: ____

Gender_________ Marital status___________________ Ethnicity________________________

Emergency Contact: ____

<u>Presenting Concern</u> *(in client's own words)*

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____

Impact on Functioning____

Duration/Frequency/Onset____

____

Current ways of coping____

____

<u>Medical/Health Screening</u>

Appetite/Weight changes____

Nutrition__________________________________ Exercise________________________________

Sleep: ____

Recent or significant disease/disability/surgeries____

Acute or chronic pain____ Rate 0 to 10________

Current medications____

Behavioral/Cognitive Screening

Orientation to person/place/time____

Appearance/Hygiene____

Attitude____

Self appraisal____

Mood/Affect____

____

Behavior____

____

Cognitive abilities/Memory/Perceptual Concerns______________________________________

____

____

Current stressors____

____

____

Home environment____

____

____

Risk Screening

Suicidal/Homicidal ideation____

____

How recent______________________ Prior attempts/Hospitalizations__________________

Suicidal/Homicidal plan____

____

____

Viability____

Safety plan____

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____

Addictions Screening

Substance/Behavior concerns____

Frequency____

Cutting back/stopping behavior____

____

Mental Health History

Client mental health history (including previous therapy and any prior hospitalizations)________

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Family mental health history (including substance use)

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Childhood trauma (i.e. abuse, sexual assault, witness to violence, natural disasters, etc.)

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____

Adult trauma (i.e. assault, accidents, miscarriage, etc)

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____

Social Screening

Family relationships/Attachments/Structure____

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____

Siblings/Number/Relationships ____

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____

Children/Number/Relationships____

____

____

Peer relationships/Attachments____

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____

Sexual history (i.e. age of first interaction, previous pregnancies, miscarriages, abortion, history of, risk, use of pornography, any history of sexual dysfunction, satisfaction)

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Additional support/Resources____

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Multicultural/Spiritual Screening

Cultural/Ethnic/LGBT identity____

____

Religious identity/Spiritual beliefs____

____

Impact of multicultural factors (including subculture membership and/or geographical cultural influences) on presenting concerns____

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____

Strength Screening

Occupational status/History____

Job satisfaction____

Education____

Leisure activities/Talents/Interests____

____

Community involvement/Volunteer activities____

Self-care strategies____

____

Stress management strategies____

____

Client strengths____

____

Is there anything else that would be important for me to know about you?___________________

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____

<u>Client's Vision/Goals for Treatment</u>

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____

Referral source ____

Reason for referral____

____

Clinician____ **Date of intake**_____________