

Intake Assessment Form

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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:
