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Intake Assessment Form

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

Client Contact Information

Name: (First) ______________________________ (Last) _________________________________

Address: ____

E-mail 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 (circle one)? 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: ______

Previous psychiatric hospitalizations? Yes No

Reasons for hospitalization: ______

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* case manager 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: