Client Intake Information

☐ **New**
☐ **Update**

Name :_____ Date of assessment:_____

1. Presenting Problem(s):

A. What is your presenting problem / why are you here?

B. Describe precipitating events:

C. What is your current living situation? (*List names and ages of all members living in your household)*

2. Lifespan / Developmental History:

A. Health at birth:

B. Developmental milestones: ☐ Within normal limits

C. Special services received during lifetime:

D. Other lifespan/developmental issues and interests/hobbies: *(include mid-life, senior/elder, other issues)*

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Name: _____ _____

3. Education and Occupation:

A. School currently attending, if applicable: _____ Grade: _____

_____

B. Education history: *(include learning problems, school issues*). Highest grade completed:

C. Occupation and employment history: *(present and past, include # of years worked, and reasons for periods of unemployment)*

D. Occupational skills / training:

4. Family of Origin History:

A. Family history, please include current and past medical & psychiatric history:

B. Family's and client's physical / sexual / emotional abuse history:

C. Family's substance use / abuse history:

5. Client's Current and Significant Past Social Supports, Family Supports, Significant Relationships, Religious and Spiritual Supports/Affiliations:

6. Ethnic/Cultural Background, Acculturation Issues:

7. Client's Legal History:

☐ Probation ☐ Parole ☐ Restraining Order ☐ Child Welfare Services

☐ Conservatorship ☐ D.U.I. ☐ Other issues ☐ None reported

(describe and, if currently involved, give name of probation officer, parole office, or case manager and estimated start and end dates)

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Client Name: _____ _____

8. Substance Use: *(alcohol and other drugs, check all that apply)* ☐ No substance use reported

A.

☐ Caffeine	☐ Alcohol	☐ Stimulants	☐ Barbiturates
☐ Tobacco	☐ Inhalants	☐ Sedatives	☐ Methamphetamines
☐ Over-the-counter medication	☐ Hallucinogens	☐ Tranquilizers	☐ Opiates
☐ Prescription medication	☐ Marijuana	☐ Cocaine	☐ Methadone
☐ Other; please identify:			

Substance	Age of 1st Use	Amount/ Frequency	Duration of Use	Date of Last Use	Period of Heaviest Use	Amount Used in Last 24 hrs.

B. Do you have a history of withdrawal, DTs, blackouts (loss of time), seizures, etc.? ☐ Yes ☐ No

C. What happens when you stop using?

D. What is the longest period of sobriety? _____ When? _____

E. Have you received treatment for drug or alcohol issues? ☐ Yes ☐ No
(if yes, list in-patient providers, out-patient, providers, services received, dates of service; and outcomes)

9. Client's Mental Health Services History:

A. Current and past psychiatric history: ☐ No psychiatric history

B. Current service provider(s):

C. Past service provider(s): *(include in-patient, out-patient; provider names, dates, therapeutic interventions and outcomes)*

Client Name: _____ _____

10. **Medical History:** *(document significant past and present medical conditions, including allergies)* **(ATTACH RELEASES)**

☐ No outstanding medical problems
☐ No known allergies
☐ Current medical conditions: _____

_____

Primary Care Physician's name and phone #: _____

Date of last physical examination: _____

List alternative treatments/therapies: *(i.e., biofeedback, acupuncture, hypnosis, etc.)*

11. **If Lab Tests Were Done, Describe Results:** ☐ Not applicable

12. **Medication History:**

A. Current psychiatric medications: ☐ None

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

B. Past psychiatric medications: ☐ None

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

C. Other medications: ☐ None
(include non-psychiatric prescriptions and alternative medications, i.e., homeopathic, herbal remedies)

Drug Name	Dose/ Frequency	Benefit/ Side Effects	Prescribed By: (Dr.'s Name)	When Prescribed?	When is Next Refill Required?

D. Medication allergies or adverse reactions: ☐ None known

Drug Name	Reaction

E. Do you follow medication regime? ☐ Yes ☐ No Explain: _____

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Client Name: _____ _____

13. Current Symptoms/Problems: *(rate severity and duration for each)*

Key:	**Severity Rating:**	**1 = Mild**	**2 = Moderate**	**3 = Severe**	
	Duration Rating:	**1 = Less Than 1 Month**	**2 = 1 - 6 Months**	**3 = 7 - 11 Months**	**4 = More Than 1 Year**

	Severity	Duration		Severity	Duration
1. Anxiety			15. Poor Self Care Skills		
2. Panic Attacks			16. Bizarre Thoughts/Behavior		
3. Phobia			17. Paranoid Ideation		
4. Obsessive Compulsive			18. Gender Issues		
5. Somatization			19. Eating Disorders		
6. Depression			20. Poor Judgment		
7. Impaired Memory			21. Lack of Support System		
8. Impaired Concentration			22. Poor Interpersonal Skills		
9. Loss of Interest			23. Conduct Problems		
10. Loss of Energy			24. School Problems		
11. Sexual Dysfunction			25. Family Problems		
12. Sleep Disturbance			26. Indep. Living Problems		
13. Appetite Disturbance			27. Distractibility		
14. Weight Change			28. Other: _____		

Please describe symptoms / problems above in detail:

14. Assessment of Risk:

A. Are you currently experiencing any of the risk factors below: *(check all that apply)*

- Suicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
- Homicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
- If risk exists, I am able to contract not to harm: ☐ Self ☐ Others
- Impulse control: ☐ Sufficient ☐ Moderate ☐ Minimal ☐ Inconsistent ☐ Explosive
- Substance abuse: ☐ None ☐ Abuse ☐ Dependence ☐ Unstable remission
- Medical risks: ☐ No ☐ Yes If "Yes", explain: _____

B. Risk history: *(explain any significant history of suicidal, homicidal, impulse control, medical or substance abuse behavior that may affect yours current level of risk or impairment to functioning. Include description of plan / ideation / intent checked above)*

15. Describe Your Strengths & Assets in Achieving Your Treatment Goals: