CLINICAL INTAKE ASSESSMENT

Client Name: _____

Date:____/____/_____

Parent/Guardian Name (if under 18):
_____

Address:

_____
street
_____
city state zip

Marital Status:

□ Never Married □ Domestic Partnership
□ Married □ Divorced
□ Separated □ Widowed

Date of Birth:_____ Age: _____

Race/Ethnicity: _____

Phone numbers:

Home: _____ (Message:yes/no) Work: _____ (Message: yes/no)

Cell: _____ (Message: yes/no Text: yes/no)

Email Address: _____ Can I email you? yes/no

Emergency Contact:
_____
(REQUIRED) name relationship phone

Insurance/EAP Provider: _____
EAP Auth Number:_____

Subscriber ID Number: _____
Group#:_____

Presenting Problem:

_____

_____

_____

How Is This Problem is Affecting Daily Life:

_____

_____

_____

What Would You Like to Accomplish in Therapy:

_____

_____

_____

Situational/Stress Factors: (Greater stress than usual in the past two years):

Yes	No		Yes	No	
__	__	Death	__	__	Serious Illness
__	__	Job Loss	__	__	Disability
__	__	Moving	__	__	Marriage
__	__	Divorce	__	__	Finances
__	__	Other: _____	__	__	Other: _____

Depressive Symptoms ☐ Not present ☐ Present

☐ Depressed Mood

☐ Diminished interest/pleasure (nearly every day for at least 2 weeks)

And 4 or more of the following nearly everyday:

☐ Decreased/increased appetite ☐ Difficulty concentrating/ Difficulty Making Decisions

☐ Insomnia/hypersomnia ☐ Recurrent thoughts of death

☐ Fatigue or loss of energy ☐ Feelings of worthlessness or excessive/inappropriate guilt

Previous Counseling - yes/no

When? _____ Was it helpful?_____

Living with you:

Name	Age	Gender	Relationship
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

#of marriages: _____

current relationship satisfaction, on a scale of 1-10 _____

# of children-names/ages

_____

Current Employment Status/School, Length of time _____

On a scale of 1-10, how would you rate your job satisfaction? _____
Why? _____

Highest Education Level: _____

Current Prescription Medications: yes/no (please continue on back if necessary)

Name – condition prescribed for	dosage/frequency	length of time on med

Name of MD/Psychiatrist: _____
Contact #: _____

Any Previous Diagnosis:

_____

Have you ever been suicidal? yes/no If yes, please detail date (s)

_____

_____

Have you ever attempted suicide? yes/no If yes, please detail method, and any help received

_____
_____
_____

Have you ever been in the hospital for mental health concerns? yes/no If yes, give dates, name of hospital and length of stay.

_____
_____
_____

Currently Feeling Hopeless/Helpless: yes/no
Current feeling suicidal? yes/no

Do you have any religious/spiritual involvement? yes/no - please specify:

_____
_____
_____

What are some of your strengths? Things about you that have helped you through the years?

_____
_____
_____

What are some of your weaknesses? Things about you that have held you back through the years?

_____
_____
_____

Family History (addiction – mental/physical illness – suicide)

_____
_____
_____

Alcohol/Drugs:

_____

Abuse Physical:

Sexual:

Emotional:

Domestic Violence:

Arrests

Medical History/Concerns:

THERAPIST USE ONLY

MENTAL STATUS EXAM SECTION

APPEARANCE	n/a - ok	slight	mod	severe
Unkempt, disheveled	☐	☐	☐	☐
Clothing: dirty, atypical	☐	☐	☐	☐

AFFECT	n/a - ok	slight	mod	severe
Inappropriate to thought	☐	☐	☐	☐
Increased lability	☐	☐	☐	☐

Odd phys. characteristics	☐	☐	☐	☐	Blunted, dull, flat	☐	☐	☐	☐
Body odor	☐	☐	☐	☐	Euphoria, elation	☐	☐	☐	☐
Appears unhealthy	☐	☐	☐	☐	Anger, hostility	☐	☐	☐	☐
					Depression, sadness	☐	☐	☐	☐
POSTURE					Anxious	☐	☐	☐	☐
Slumped	☐	☐	☐	☐	Irritable	☐	☐	☐	☐