Initial Assessment Intake

Name: ____Date: __________

Please describe the problem that brought you here today:

Check all the behaviors and symptoms you consider problematic:

Seasonal mood changes ___
Sadness/depression ___
Loss of pleasure/interest ___
Hopelessness ___
Thoughts of death ___
Self-harm behaviors ___
Frequent crying spells ___
Loneliness ___
Low self-worth ___
Guilt/shame ___
Fatigue ___
Change in appetite ___
Lack of motivation ___
Withdrawal from people ___
Anxiety/worry ___
Panic attacks ___
Fear being away from home ____
Social discomfort ___
Obsessive thoughts ___
Compulsive behavior ___
Aggression/fights or frequent arguments ___
Irritability/anger ___
Homicidal thoughts ___
Intrusive memories or flashbacks ___
Recurring or disturbing memories ___
Nightmares ___
Hearing voices ___
Visual hallucinations ___
Suspiciousness/paranoia ___
Racing thoughts ___
Excessive energy ___
Wide mood swings ___
Sleep problems ___
Distractibility ___
Hyperactivity ___
Impulsivity ___
Boredom ___
Poor memory/confusion ___
Eating problems ___
Gambling problems ___
Computer addiction ___
Problems with pornography ___
Sexual problems ___

Relationship problems ___
Work/school problems ___
Recurring or disturbing memories ___

Are your problems affecting any of the following?

handling everyday tasks ___
work/school ___
recreational activities ___
self-esteem ___
housing/living situation ___
sexual activity ___
interpersonal/elationships ___
legal matters ___
health ___
hygiene ___
finances ___

Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:

Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:

Have you recently been physically hurt or threatened by someone else?

Family and Developmental History

Relationship Name Age Quality of Relationship (good or problematic)

Mother ____

Father ____

Stepmother ____

Stepfather ____

Siblings ____

Spouse/partner ____

Children ____

____

____

Family Mental Health Problems (List name of member next to the condition):

Depression ___
Bipolar disorder ___
Suicide Attempts ___
Anxiety ___
Hyperactivity ___
Panic attacks ___

Anger ___
Abusive ___
Psychosis ___
Eating disorder ___
Alcohol abuse ___
Drug abuse ___

Please check if you have experienced any of the following types of trauma or loss:

Emotional abuse ___
Sexual abuse ___
Physical abuse ___
Parent substance abuse ___
Teen pregnancy ___
Neglect ___
Violence in the home ___
Crime victim ___
Parent illness ___
Place child for adoption ___
Lived in a foster home ___
Multiple family moves ___
Homelessness ___
Loss of a loved one ___
Financial problems ___

Previous Mental Health Treatment

Yes	No	Type of treatment	When	Provider/program	Reason for treatment
___	___	Outpatient counseling	______	______________________________	______________________________
___	___	Mental health medication	______	______________________________	______________________________
___	___	Psychiatric hospitalization	______	______________________________	______________________________
___	___	Drug/alcohol treatment	______	______________________________	______________________________
___	___	Self-help/support groups	______	______________________________	______________________________

Interpersonal/Social/Cultural Information

Please describe your social support network check all that apply:
Family ___
Neighbors ___
Friends ___
Students ___
Coworkers ___
Support/self-help group ___
Community group ___
Religious/spiritual center ___

To which cultural or ethnic group, do you belong?

If you are experiencing any difficulties due to cultural or ethnic issues, please describe:

How important are spiritual matters to you?
Not at all ___
A little ___
Somewhat ___
Very much ___

Please describe your strengths, skills, and talents:
____

Describe any special areas of interest or hobbies, art books, physical fitness: ____

Miscellaneous Information

Employment

Employer ____

Position ____

Length of time at this position _____________________

Job duties ____

Stress level of this position ________________________

Other jobs you've held____

Education

Are you currently attending school? Yes ______ No _____

High school graduate or GED _________ year______________

Associate degree __________Year _____________ Major area of study__________________________________

Undergraduate degree __________Year ____________ Major area of study_______________________________

Graduate degree___________ Year ____________ Major area of study___________________________________

Military Service

Yes_____ No____ Have you ever been/are you currently in the military?

Branch_____________________________________ Date of Discharge______________ Type of Discharge______________________________

Rank_____________________ Were you in Combat? ____

Name: ____Date: __________

Legal History

Yes_____ No____ Have you ever been convicted of a crime - misdemeanor or felony? If yes, please explain_____________

Are you're currently involved in any divorce or child custody proceedings? If yes, please explain______________________

____

Substance Use History

Substance Type	Current use pattern (last 6 months)				Past Use			
	Yes ___	No___	Frequency	Amount	Yes ___	No___	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								

Marijuana ____

Cocaine/crack cocaine ____

Ecstasy/ MDMA ____

Heroin ____

Inhalants____

Methamphetamines ____

Prescription opiates____

PCP/LSD ____

Steroids ____

Other ____

Yes____ No____ Have you had withdrawal symptoms when trying to stop using any substances if yes, please explain: _____________________

Yes ____No_____. Have you ever had problems with work, relationships, health, legal, tec., due to your substance use?__________________

Medical information

Date of last exam: _________________

Have you experienced any of the following medical conditions during your lifetime?

Allergies____
Chronic pain____
Dizziness/fainting ____

Name: ____Date: __________

High fevers ____
Sexually transmitted disease ____
Asthma ____
Surgeries ____
Meningitis____
Diabetes ____
Abortion ____
Headaches ____
Serious accident ____
Seizures ____
Hearing problems ____
Sleep disorder ____
Stomach aches ____
Head injury TBI ____
Vision problems ____
Miscarriage____
Other____

Please list any current health concerns:

____

Current prescription medications: ____