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INTAKE FORM/DIAGNOSTIC ASSESSMENT

Name:		**Date:**
Address:		**Telephone Numbers:** **Best times to call:**
Emergency Contact Information:		
Date of Birth:	**Age**	**Birthplace:**

Marital status:	**Previous marriages:**
Children:	**Step-Children:**

CURRENT LIVING SITUATION (Own home? How do you support yourself?

EDUCATIONAL HISTORY – College? HS? What was your experience like in school

VOCATIONAL HISTORY – Do you work? Favorite job? Like job? Job goals? Career goals? Military History?

Experiencing legal situation, unemployment, financial problems, parole, probation?

PRESENTING CONCERN/REASON FOR COUNSELING

Describe concern:

Presenting concerns intensity: How do you rate the intensity of the concern that brought you in:				
1 Not intense	2	3 Moderately intense	4	5 Extremely Intense

Problem duration: Approximately how long have you had the current problem?

Coping attempts: How have you dealt w/this problem on your own?

History of Mental Health Services and Diagnoses:

What is your most specific goal in counseling?

Major goals in life:

Does your current mental health prevent you from obtaining these goals?

Have you had suicidal thoughts recently?

Have you ever had suicidal thoughts?

Have you ever intentionally inflicted harm upon yourself?

FAMILY HISTORY

Place of Birth:	**Birth Order**:	**# Siblings**:
Name of Sibling:	**Gender/Age**	**Closeness**
Family information - (Mother/Father age, location, closeness, disciplinary measures, deaths in family, violence in home, trauma, frequent or traumatic location, serious illness in family, psychiatric disorders in family, suicide in family, physical or sexual abuse):		
Who in your family do you feel closest to, distant from, most conflict with, most supportive?		

Describe a favorite memory from your childhood?

What do you consider is some of your best traits and strengths?

Is there anything that you do not like about yourself?

Do you consider yourself shy or inferior? If so, has this affected your lifestyle?

Problems sleeping/nightmares?

Hobbies/Music/recreation:

Diet/caffeine/exercise:

MEDICAL HISTORY:

Current medical complaints/problems:

History of:	Y/N	Describe
Serious Injury		
Serious Illness		
Head Injuries		
Seizures		
Allergies		
Physical Limitations		

Current Medications:

Name	Dosage	Duration Taking

Past psychotropic medications used:

Name	Dosage	Duration Taking

How do you feel about your present state of health?

Family physician (name and location):

ALCOHOL OR ILLEGAL DRUG USE:

Do you currently use alcohol or illegal drugs?		
Substance	**Amount**	**How often**

	Y/N
Have you ever had a CD evaluation?	
Have you ever been told you are an alcoholic	
Do you feel that your alcohol/drug use is abnormal?	
Have you ever had a blackout?	
Approximately how many times have you been drunk or high in the last year	

History of chemical dependency treatment?

How has chemical dependency affected your life/Family history?

Codependency/gambling/tobacco:

SYMPTOMS	Y/N	Describe (duration, frequency, etc.)
1. Mood		
a. Depressed mood		
b. Elevated mood		
c. Cyclic		
2. Sleep		
a. Insomnia		
b. Hypersomnia		
c. Decreased Need		
3. Appetite problems		
4. Weight change		
5. Interest in Activities		
6. Energy		
7. Concentration Difficulty		
8. Hopeless/Helpless feelings		
9. Worthless/guilt feelings		
10. Crying		
11. Suicidal Ideation		
12. Homicidal Ideation		
13. Sexual Interest/Dysfunction		
14. Hallucinations		
15. Delusions		
16. Thought Control		
17. Alcohol Abuse/Dependency		
18. Chemical Use/Dependency		
19. Panic Attacks		
20. Phobias		
21. Anxiety (generalized)		
22. Traumatic Events		
23. Flashbacks		
24. Nightmares		
25. Avoidance		
26. Irrational thoughts		
27. Obsessions/compulsions		
28. Memory		
29. Physical condition		
30. Anorexia		
31. Bulimia		
32. Aggression/Anger		
33. Hyperactive		
34. Impulsive		
35. Tics		
36. Socially Withdrawn		
37. Poor Social Skills		
38. Indiscriminate boundaries		
39. Responsibility		
40. Confusion or foggy thinking		
41. Decision making		
42. Phobias/Fears		

Additional Information?