Intake Assessment Form

Name:		**Date:**
DoB:	**Age:**	**Cell#:**
Sex:	**Gender:**	**Email:**
Ethnicity:		**Preferred Contact Method:**
Address:		
Emergency Contact Name:	**Relationship:**	**Cell#:**

***If you have insurance, please list down the details below (i.e., insurance, subscriber/group number, co-pay, etc.)**

Questions

What are the problems you are experiencing?

Why did you decide to seek help?

How do you currently cope with your problems?

Have you thought of harming yourself or wishing you were dead? ☐ **Yes** ☐ **No**
Please elaborate:

Have you thought of hurting or killing someone else? ☐ **Yes** ☐ **No**
Who?

What do you wish to achieve after counseling/what would you like to get out of counseling?

Counselling Treatment History

Are you currently in therapy or have you had therapy in the past? ☐ **Yes** ☐ **No**
If yes, why, with whom, starting date, and duration? Was it helpful?

Personal and Family Medical History

☐ **Anemia**	☐ You	☐ Family Member:	
☐ **Liver Disease**	☐ You	☐ Family Member:	
☐ **Kidney Disease**	☐ You	☐ Family Member:	
☐ **Diabetes**	☐ You	☐ Family Member:	
☐ **Asthma/Respiratory Problems**	☐ You	☐ Family Member:	
☐ **Cancer**	☐ You	☐ Family Member:	
☐ **Heart Disease**	☐ You	☐ Family Member:	
☐ **Epilepsy/Seizure**	☐ You	☐ Family Member:	
☐ **High Blood Pressure**	☐ You	☐ Family Member:	
☐ **High Cholesterol**	☐ You	☐ Family Member:	
☐ **Liver Problems**	☐ You	☐ Family Member:	
☐ **Other:**	☐ You	☐ Family Member:	

Any additional personal or family medical history?

Do you have any psychiatric history, and have they been treated with medication? If yes, what were the diagnosis and medication/s, and were they effective?

Personal and Family Medical History (Continued)

Please list ALL of the medications - current and past - their dosages, and your reaction or side effects to them.

Medication	Dosage	Estimated Start Date	Adverse Reaction

Have you undergone surgeries or have been hospitalized for an illness or injury?
Please elaborate on the reason, the date, and where it happened?

Substance Use

Have you consumed/are you consuming/using any of the following? If yes, how many a day?

☐ **Coffee**	☐ Past	☐ Present	Frequency:	
☐ **Soda**	☐ Past	☐ Present	Frequency:	
☐ **Tea**	☐ Past	☐ Present	Frequency:	
☐ **Alcohol**	☐ Past	☐ Present	Frequency:	
☐ **Tobacco**	☐ Past	☐ Present	Frequency:	
☐ ***Drugs**	☐ Past	☐ Present	Frequency:	
☐ ***Prescription Medication**	☐ Past	☐ Present	Frequency:	

***If you have tried drugs, which one, in particular, have you tried/are currently using?**

***If you're taking/have taken prescription medications, have you overused/self-medicated with said medication?**

Substance Use (Continued)

Do you think you have a problem/have you had any problems with substance abuse, especially with alcohol, drugs, or prescription medicine?

***If you have a problem with substance abuse, have you been treated for it?** ☐ **Yes** ☐ **No**
Please elaborate:

What may have triggered the problem? (e.g., peer pressure, issues in the family, financial situation, etc.)

Has anyone raised any concerns about your alcohol, drug, or prescription medication?

Have your problems negatively affected certain areas of your life? If yes, which ones? (e.g., family, school, emotional, financial, social):

Family Background

Possible Guiding Questions:
Were you adopted? Who raised you? Do you have any siblings? What are their ages? Parent's relationship with each other? What is your relationship with your family members? What kind of family would you say you grew up with?

Are/Were you married in a relationship? ☐ **Yes** ☐ **No**
Any problems experienced in current or previous relationships? What are the results of those problems?

Educational History

Possible Guiding Questions:
Are you enrolled in school now? Are you a full-time or part-time student? Highest grade completed? How well did you do in school? How were your relationships with your teachers and peers? Were there any experiences worth nothing (i.e., bullying, being diagnosed with a learning disability, being suspended, failing, attending special classes, frequently moving, etc.)

Occupational History

Possible Guiding Questions:
Are you currently employed? What are your hours worked per week? What is your occupation? Where do you currently work? How long have you been employed? Have you served in the military? If so, which branch and when? What type of discharge have you received?

Is there anything else you would like us to know about?

Patient's Signature:	**Date:**
Reviewed By:	**Date:**