

Intake Evaluation

Identifying Information

Clients' Name: _____ Date: _____

Partner's Name (if being seen as a couple) _____

Address: _____ City, State, ZIP: _____

Phone: _____
(home) (work) (Partner)

May we leave messages for you at home/work? Y N

Gender: M: F: Age: _____ DOB: _____ Married? Y N

Others living in the home: _____

(Name/DOB/relationship to client)

Education (self): _____ Partner _____

Occupation (self): _____ Partner _____

Employer: _____

SSN (self): _____ Partner: _____

Emergency Contact: _____

Referred by: _____

Insurance Information

Name of Insured: _____ DOB: _____

Relationship of client to insured? _____ Employer: _____

Ins. Company _____

Is there secondary insurance or supplemental insurance? _____

Patient or authorized person's signature: I authorize the release of any medical or other information necessary to process a claim. I authorize payment of medical benefits to the provider of services.

(signature of client/responsible party) Date: _____

Presenting Problem

Describe the problem that brought you here today:

Check any of the symptoms you are having		
Depression	Feeling Hopeless	
Extreme Sadness	Feeling Tearful	
Trouble Concentrating	Change in Sleeping Habits	
Memory Problems	Lack of Energy	
Change in Eating Habits	Weight Changes	
Feelings of Extreme Happiness	Changes in sexual interest/function	
Trouble performing job	Problems getting along with friends/family	
Lack of enjoyment in usual activities	Feeling Stressed	
Self Esteem Problems	Easily Irritated	
Perfectionism	Feeling guilty	
Obsessions/Compulsions	Feeling Nervous	
Feeling Fearful	Sudden feelings of Panic	
Physical complaints of pain	Muscle Tension	
Problems with Anger	Acting Violently	
Thoughts of hurting yourself or others	Thoughts of killing yourself or others	

This space reserved for additional comments by clinician:

Have you ever been in counseling before? Y N

Name of Therapist(s)	Dates of Service:
Explain what happened?	

Medical Information

Have you seen a doctor within the last year?	
Why did you see the doctor?	
Who is your doctor?	Phone:
Are you taking any medications, prescription or over the counter?	
Please list medications:	
Allergies?	

Substance Use History

Do you use/have you used tobacco (any form)	Current:	Past:	No:
Do you use/have you used alcohol	Current:	Past:	No:
Do you use/have you used caffeine (any form inc. soda)	Current:	Past:	No:
Do you use have you used recreational drugs?	Current:	Past:	No:

Is there anything else you would like me to know?
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