# Intake Assessment

## ➨ General Information

Name _____ Date of Birth _____ Age _____

Address _____ City_____State _____ Zip Code_____

Telephone Home _____Work _____Cell _____

May we contact you at home? ❒ YES ❒ NO at work? ❒ YES ❒ NO on your cell phone? ❒ YES ❒ NO

E-mail Address _____ Can we contact you via e-mail? ❒ YES ❒ NO

Social Security # _____ Are you receiving mental health services anywhere else? ❒ YES ❒ NO

Gender ❒ Female ❒ Male Religious Affiliation? _____

Ethnicity ❒ African American ❒ American Indian/Alaskan Native ❒ Asian/Pacific Islander ❒ Jewish

❒ European American (Caucasian) ❒ Hispanic/Latino ❒ Other_____

Referral Source _____ Release of Information ❒ YES ❒ NO

Fee Reimbursement ❒ Cash ❒ Credit Card ❒ Insurance (In-Network) ❒ Insurance (Out-of-Network)

_____

Type of consultation you are seeking:

❒ Individual ❒ Couple/Marriage ❒ Family ❒ Group ❒ Other _____

## ➨ Emergency Contact

Release of Information ❒ YES ❒ NO

Name _____ Relationship _____

Address _____ City_____State _____ Zip Code_____

Telephone Home _____Work _____Cell _____

## ➨ Family Contact

Release of Information ❒ YES ❒ NO

Do you want family members/friends involved in your

treatment planning and provided with updated progress? ❒ YES ❒ NO

If so, who do you want involved? ❒ parents ❒ siblings ❒ spouse ❒ offspring ❒ other _____

## ➨ Description of Presenting Problem(s)

State in your own words the nature of what brings you here today—your issues, concerns, and problems:

_____

_____

_____

Estimate the severity of your issues/problems: Severity Index _____

❒ none ❒ low ❒ moderate ❒ high ❒ very high ❒ catastrophic

Why—How is it affecting your life?_____

_____

Please check any of the following areas that are currently presenting you stressors:

| | | |
|---|---|---|
| ❒ Self-care | ❒ Spouse/Partner | ❒ Living Situation |
| ❒ Leisure | ❒ Children | ❒ Education/Training |
| ❒ Religion/Spirituality | ❒ Family | ❒ Employment |
| ❒ Financial | ❒ Social Life | ❒ Legal Issues |
| ❒ Transportation | ❒ Mental Health System | ❒ Substance Abuse |
| ❒ Mental Illness | ❒ Physical Illness | ❒ Eating Disorder |
| ❒ Emotional Abuse | ❒ Physical Abuse | ❒ Sexual Abuse |

❒ Other _____

Duration of issues/problems—When did they begin? _____(date) Duration Index _____

❒ 2 weeks or less ❒ 2 to 4 weeks ❒ 1 to 6 months ❒ 6 to 12 months ❒ 1 to 5 years ❒ more than 5 years

Was there a specific circumstance to cause the issues/problems? _____

_____

How would you rate your coping skills: Coping Index _____

❒ none ❒ inadequate ❒ somewhat ❒ adequate ❒ above average ❒ outstanding

What makes your life work as well as it does?_____

_____

## ➨ Safety Assessment

Means _____

Do you currently have suicidal thoughts? ❒ YES ❒ NO

Do you have the intent of following through with your suicidal thoughts? ❒ YES ❒ NO

Do you have a plan? ❒ YES ❒ NO If yes, what is it? _____

Do you have thoughts of harming someone else? ❒ YES ❒ NO

Explain _____

## ➨ Mental Health Services

Please list previous mental health services you have received (therapy, groups, day treatment, partial, hospitalizations)?

When/Date Where/Location By Whom/Name & Telephone

_____

_____

_____

_____

_____

_____

_____

What did you find helpful? _____

_____

_____

_____

Current Medications Dose Why Prescribed?

_____

_____

_____

_____

_____

_____

_____

_____

What do you believe your diagnosis to be? _____

_____

_____

Psychiatrist _____ Telephone _____ Release ❒ YES ❒ NO

Address _____

Therapist _____ Telephone _____ Release ❒ YES ❒ NO

Address _____

Family Doctor _____ Telephone _____ Release ❒ YES ❒ NO

Address _____

## ➨ Goals

Please describe your goal(s) for therapy—How would you like to enhance your quality of life?

_____

_____

_____

_____

Do you expect therapy in your situation to be:

❒ 1 to 10 sessions ❒ 11 to 20 sessions ❒ more than 20 sessions ❒ lifetime/ongoing as needed

On a scale of 1 (low) to 10 (high) I would rate my **energy** level as _____

On a scale of 1 (low) to 10 (high) I would rate my **willingness to follow-through** with what I learn from therapy _____

On a scale of 1 (low) to 10 (high) I would rate my **self-esteem** as _____

## ➨ Family Psychiatric History

Have any of your family members (blood relatives) struggled with the following mental health issues? Please check appropriate columns. ❒ Check here if adopted and/or biological family psychiatric history unknown

| | Father | Mother | Brothers | Sisters | Aunts/Uncles | | Grandparents | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Paternal | Maternal | Paternal | Maternal |
| Substance Abuse | | | | | | | | |
| Depression | | | | | | | | |
| Anxiety | | | | | | | | |
| Bipolar Disorder-Manic/Depressive | | | | | | | | |
| Schizophrenia - Psychotic Episode | | | | | | | | |
| Suicide Attempt | | | | | | | | |
| Psychiatric Hospitalization | | | | | | | | |

## ➨ Current Psychological Symptoms

Check any of the following that you have been experiencing in the past 3 months:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Depressed/Unhappy | | Irritable | | Insomnia | | Excessive Worries |
| | Low Motivation | | Forgetful | | Racing Thoughts | | Social Anxiety |
| | Difficulty Concentrating | | Appetite Change | | Impulsive/Risk-Taking | | Obsessive Thinking |
| | Socially Withdrawn | | Low Self-Esteem | | Too Much Energy | | Rituals to Lower Anxiety |
| | Excessive Sleeping | | Low Sex Drive | | Tense/Stressed | | Anxiety; Past Trauma |
| | Nightmares | | Worthless/Guilty | | Restless/Pacing | | Feeling "Numb" |
| | Tearful/Crying Spells | | Hopelessness | | Angry Outbursts | | Flashbacks While Awake |
| | Fatigue | | Suicidal Thoughts | | Legal Trouble | | Avoiding People |
| | Confused Thoughts | | Loss of Interest/Activities | | Panic Attacks | | Drinking Excessively |
| | Confused Feelings | | Difficulty with Decisions | | Feeling Lonely | | School Problems |
| | Fears/Phobias | | Self-Injurious Behaviors | | Family Problems | | Relationship Problems |
| | Work Problems | | Financial Problems | | Coping with Abuse | | Gambling Problem |

Check any of the following physical sensations that often apply:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Headaches | | Dizziness | | Vomiting | | Hearing Things |
| | Tingling | | Heart Racing | | Stomach Problems | | Visual Disturbances |
| | Muscle Spasms | | Blackouts | | Neck/Back Pain | | Tics/Twitches |
| | Muscle Tension | | Flushing | | Trouble Swallowing | | Odd Sensations |
| | Itchy or Burning Skin | | Excessive Sweating | | Bowel Problems | | Tremors |
| | Dry Mouth | | Chest Pain | | Chronic Pain | | Snsitivity to Touch |
| | Unable to Relax | | Fainting spells | | Weight Concerns | | Sexual Problems |

Other _____

## ➨ Substance Abuse History

Do you consume alcohol? ❒ YES ❒ NO

If yes, how many alcoholic drinks do you have on an average weekday? _____ Weekend night? _____

Do you have a history of treatment/evaluation for alcohol problems? ❒ YES ❒ NO If so, when? _____

Have you ever used street drugs, or illicit substances? ❒ YES ❒ NO

If yes, what have you used? _____

When? _____

Do you have a history of treatment/evaluation for drug related problems? ❒ YES ❒ NO If so, when? _____

Have you been seen for gambling problems? ❒ YES ❒ NO

Do you have other addictive behaviors that you have concerns about? ❒ YES ❒ NO If so, what? _____

How often, or how much do you smoke cigarettes?

❒ None, I have never smoked cigarettes.

❒ None now, I did in the past. Age when started: _____ Age when stopped _____

❒ I am currently a smoker. Age when started: _____

❒ Only occasionally ❒ Less than one pack per day ❒ One to two packs per day ❒ More than two packs per day

Have you ever used other tobacco products (cigar, pipe, chewing tobacco)? ❒ YES ❒ NO

If yes, what have you used, when, and how often? _____

Average number of caffeinated drinks per day (coffee, soda, etc) ❒ 1 ❒ 2-3 ❒ 4-6 ❒ More than 6

## ➨ Medical History

How would you describe your current health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

How would you describe that you care for yourself? ❒ Good ❒ Pretty Good ❒ OK ❒ Not at all

Please list any current and/or chronic medical problems, surgeries, or significant injuries:

_____

_____

How many hours of sleep per night do you get? _____ What time do you normally go to bed? _____ Get Up? _____

Do you have any problems with sleep? _____

Have you ever had a concussion, head injury, or lost consciousness? ❒ YES ❒ NO

If yes, please explain: _____

Last physical exam? _____ Last eye exam? _____

Did you have the following labs? ❒ Thyroid – TSH _____ (0.30-5.00) ❒ Blood Sugars – A1C _____ (4%-6% normal)

❒ Iron ❒ B12 ❒ Hormone/Testosterone Level ❒ Other _____

Do you have any specific concerns about your physical health?

_____

_____

_____

## ➨ Social/Developmental History

Where were you born? _____ Where did you grow up? _____

I have _____ brothers and _____ sisters. I was born: ❒ 1st ❒ 2nd ❒ 3rd ❒ 4th ❒ 5th ❒ 6th ❒ 7th ❒ Other _____

Relationship with my siblings is/was ❒ close ❒ distant ❒ hostile ❒ neutral ❒ non-existent

Parents are (check all that apply): ❒ never married ❒ still married ❒ separated ❒ divorced ❒ deceased ❒ unknown

If parents divorced, how old were you? _____ Who raised you? _____

Father: Age _____ Occupation _____ My childhood relationship with him was _____

If deceased, age/date/cause of death _____

Mother: Age _____ Occupation _____ My childhood relationship with her was _____

If deceased, age/date/cause of death _____

If applicable:

Relationship to step-father is ❒ close ❒ distant ❒ hostile ❒ neutral ❒ non-existent

Relationship to step-mother is ❒ close ❒ distant ❒ hostile ❒ neutral ❒ non-existent

If adopted, have you made a connection with your biological parents? ❒ YES ❒ NO

Overall, my childhood was ❒ Very Happy ❒ Happy ❒ OK ❒ Unhappy ❒ Very Unhappy

Have you ever been abused? ❒ YES ❒ NO If so, what kind? ❒ Emotional/Verbal ❒ Physical ❒ Sexual

If applicable, who abused you? _____

Check any areas that applied to you in your childhood and/or adolescent years:

| | | | | | |
|---|---|---|---|---|---|
| | Behavioral Problems | | Emotional Problems | | Legal Trouble |
| | Sleepwalking | | Bed Wetting | | Frequent Fighting |
| | Family Problems | | Anxiety | | Fire Setting |
| | Cruelty to Animals | | Learning Disability/ADHD | | Stealing |
| | Running Away | | Medical Problems | | Social Problems |
| | Alcohol Abuse | | Drug Abuse | | School Truancy |
| | Stuttering | | Anger Control Problems | | School Problems |
| | Depression | | Self-Harm | | Feeling Alone |

## ➨ Current Life Situation

❒ Never Married ❒ Separated ❒ Divorced, but not remarried

❒ Married, how long? _____ ❒ Widowed ❒ Divorced, and remarried

❒ Living with significant other, how long? _____

Spouse/Significant Other's age _____ Spouse/Significant Other's occupation _____

Have you or your spouse/significant other been married before? If so please explain:

_____

_____

_____

If you have children, please list names, ages, and living arrangements:

_____

_____

_____Are you having parenting concerns? ❒ YES ❒ NO

Check all that apply with regard to your present marriage/relationship:

❒ Close and Trusting ❒ Poor Communication ❒ Problem Trusting Spouse/Significant Other

❒ Alcohol/Drug Abuse ❒ Distant but Loyal ❒ Sexual problems

❒ Cold and Hostile ❒ Controlling ❒ Physical/Emotional/Sexual Abuse

## ➨ Educational History

How far did you go in school?

❒ Less than 12th grade

❒ GED, when? _____

❒ High School Diploma

❒ Some Technical Education

❒ Completed Technical Training _____

❒ Some College

❒ Associates Degree _____

❒ Bachelors Degree _____

❒ Some Graduate Training

❒ Graduate Degree _____

What were your grades?

❒ A ❒ B ❒ C ❒ D

❒ Presently a Student

For What _____

Where _____

Favorite Subject

_____

Ever repeat a grade in school? If so, which one and why?

_____

Were you ever suspended or expelled from school? If yes, please explain why and number of times?

_____

How social were you in school? Did you have many friends?

_____

What extracurricular activities were you involved with during school (i.e., sports, band, clubs, etc.)?

_____

## Occupational History

Are you currently employed? ❒ YES ❒ NO

If yes, what do you do? _____

Where do you work? _____

When did you start working there? _____ Do you like your present job? ❒ YES ❒ NO

If you are currently volunteering, please explain:

_____

If you are unable to work or volunteer, how do you structure your day?

_____

## Exercise and Leisure Time

What do you do for exercise and how often? _____

What limits the amount of exercise that you can do? _____

What do you do during your leisure time—for fun and pleasure?

_____

## Legal History

Are you currently facing, or do you have a history of legal problems?

❒ Commitment ❒ Stay of Commitment ❒ Probation ❒ Parole ❒ Alcohol/Drug Related

❒ Child Protective Services (CPS) ❒ Divorce ❒ Custody ❒ Unlawful Detainer ❒ Bankruptcy

❒ Other _____

## Strengths/Weaknesses

What do you consider your weaknesses/vulnerabilities?

_____

What do you consider your major strengths?

_____

## What Is Working For You

_____

_____

**What is your support network?**

_____

_____

**➨Comments or anything else you would like me to know:**

Hope Allianz's mission is to inspire and empower individuals and families to create an authentic quality of life with wisdom and knowledge while promoting mental, physical and spiritual health.

Thank you for your time, candor and helpfulness in completing this form. Dr Grande will review it and discuss it with your thoroughly at your intake session. This information is confidential and private. No one will have access to it without your written authorization.

Signature

Date