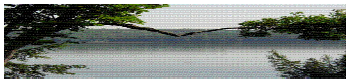

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CLINICAL INTAKE FORM

Client Name: _____ **Today's Date:** _____

DOB (Age):_____ **School/Employer:**_____

Name of Person Completing Form: _____ **Relation to client:**_____

Address of Current Residence: _____

Please provide names and relation to client of all persons residing in the home:

	Name	Relationship to Client
1.		
2.		
3.		
4.		

What problems bring you to therapy?

_____

_____

_____

_____

History of Problems:

1. Approximately when did the problems first begin?_____
2. At that time, how did it affect you? _____
3. Who besides yourself was aware of the problem? _____
4. How long did the problem last? _____
5. What did you do to attempt to solve the problem or make yourself feel better? _____

_____

_____

_____

MENTAL HEALTH HISTORY

1. In your lifetime have you participated in therapy or counseling? Yes No
2. If you answered "yes." Please complete the following mental health history chart. List your counseling experiences starting with the most recent and working your way backward in time:

Treatment Dates	Treatment Duration	Type of Therapist	Purpose	Setting In Pt	Out Pt	IOP	Res

MEDICAL HISTORY

1. In your lifetime were you admitted to a hospital for medical reasons? Yes No
2. If you have a history of hospitalization please tell us a little about it. List your hospitalization history in the order they occurred, starting with the most recent:

	Dates	How long?	What for?	Complications (if any)?
a.				
b.				
c.				
d.				

3. Do you have or have you been diagnosed with an acute or chronic medical condition? Yes No
   If yes, please list medical conditions or diagnoses:
   a. _____
   b. _____
   c. _____
   d. _____
4. Do you have a history of head trauma or injuries, e.g. concussion? Yes No

If yes, please provide the following details of each event:

Age	What caused injury?	Medical care required? (Y/N)	Describe long-term consequences.

5. Please check all the physical symptoms that apply to you and their seriousness and frequency:

Physical symptom	Not significant/not applicable	Mild or once in a while	Moderate problem	Severe Problem	Extremely severe problem
Headaches					
Dizziness					
Fainting/loss of consciousness					
Seizures					
Facial Pain					
Jaw Pain					
Jaw locking/popping					
Grinding/bruxing teeth					
Neck/shoulder pain					
Back pain					
Other muscle pain					
Chest pain					
Shortness of breath					
Tightness in chest					
Other chest problems					
Tingling/pain in arms/legs					
Cold hands/feet					
Numb hands/feet					
Nausea					
Vomiting					
Constipation					
Diarrhea					
Heartburn					
Acid reflux					
Stomach pain					
Other GI					
Hives/rashes					
Other skin problems					
Hair loss					
Cold/flu symptoms					
Bronchial infection					
Yeast infection					
Other physical symptoms					

6. Please list all past and present medications prescribed for you by a medical provider and your level of compliance:

Name of medication	Past or present?	Reason given?	Did you take as prescribed? (Y/N)	Describe side effects, if any.

7. Please list all over-the-counter medications that you routinely take:

   a. _____ b. _____

   c. _____ d. _____

8. Please list all medications or foods to which you have or have had an allergic reaction:

   a. _____

   b. _____

   c. _____

   d. _____

9. What is your physician's name and contact information? _____

_____

10. When were you last seen by your physician? _____

11. What was the purpose of that last visit? _____

PSYCHOLSOCIAL HISTORY

Birth- 6 years old

1. Did your mother have any problems during pregnancy? Yes No
2. Exposure to toxins while pregnant? Yes No
3. Complications during delivery? Yes No
4. Conditions at birth? _____

_____

5. Please check the problems below that were present from birth – 6 years old:

	High fevers
	Medical hospitalizations
	Major illness/medical problems
	Convulsions
	Toxic substance exposure
	Injuries
	Physical abuse

	Sexual abuse
	Emotional abuse
	Physical neglect
	Emotional neglect
	Extended separations from parent(s)/major caregivers

6. Please describe any odd or unusual behaviors performed between birth – 6 years old: _____

_____

_____

7. Please describe the accomplished milestone:

Milestone	Early	On time	Late/delayed
Crawl			
Walk			
Talk			
Toilet train			

8. Did anyone other than primary caregivers provide child care during birth – 6 years old? Yes No

If yes, please tell us at what age and the type of child care received: _____

_____

_____

9. Were there any separation problems during this period? Yes No

6 years old and older

1. Please check the problems below that were present from 6 years old to the present:

	High fevers
	Medical hospitalizations
	Major illness/medical problems
	Convulsions
	Toxic substance exposure
	Injuries
	Physical abuse

	Sexual abuse
	Emotional abuse
	Physical neglect
	Emotional neglect
	Extended separations from parent(s)/major caregivers

2. Please describe any odd or unusual behaviors performed between 6 years old and the present: _____

_____

_____

3. Any problems with separation from parents or primary caregivers? Yes No
4. Please use the chart to describe attitude towards school:

Period of education	Poor	Okay (Could take it or leave it)	Good	Excellent
Elementary				
Middle School				
High School				
College or Trade School				

5. Any attendance problems? Yes No If yes, please explain: _____

_____

_____

6. If there were problems in the following areas, please use the chart to explain:

Skill area	Yes	No	Explain
Learning to read			
Learning math			
Learning to write			

7. Please report average grades during each period of education (check all that apply):

Period of education	A	B	C	D
Elementary				
Middle School				
High School				
College or Trade School				

8. Was/is there any participation in Special Education Services or Child Study Team? Yes No

If yes, please explain: _____

_____

9. Were/are there problems with absenteeism? Yes No

If yes, please explain why: _____

_____

_____

10. If there was/is a history of school behavior problems, please identify what type below:

Individual	Yes	No	Fighting
Teacher			
Authority figures			
Peers			
Strangers			

11. The following refers to how you/the child relates to others. Please respond yes or no.

Relationship with others	Yes	No
Plays well with others		
Prefers being alone		
Had/has a best friend		
Hangs out with a group of friends		
Frequent changes in peer group or friend choices		
If applicable, recent change in peer group or friends		
Problems with separating from caregivers		
Has contact with extended family		
Satisfied with the number of friends and quality of friendships		

12. Please identify whether you/the child were exposed to any of the following traumatic events:

Event	Yes	No
Death		
Separations		
Violent behavior		
Physical abuse		
Emotional abuse		
Sexual abuse		
Pornographic material		

Event	Yes	No
Domestic violence		
Parental impairment (physical or mental)		
Cruelty to animals		
Natural disaster		
Other traumatic event		

13. Have you/the child performed any of the following problem behaviors?

Problem behavior	Yes	No
Accused/suspected of an illegal activity		
Convicted of illegal activity		
Incarcerated for illegal activity		
Accused/suspected of sexual offenses		
Accused/suspected of substance use		
Accused/suspected of drug trafficking, e.g., selling		
Self-injurious/self-harm/suicidal behavior		

Problem behavior	Yes	No
Self-injurious/self-harm/suicidal behavior		
History of violent behavior/hurting others		
Runaway from home/primary residence		
Bed wetting		
Fire setting		
Nightmares/night terrors		

14. Highest educational level attained (please circle one):

Preschool K-8 High School Baccalaureate Graduate School Technical Training

WORK HISTORY

1. Are you/the client currently employed? Yes No

If yes, please tell us who you work for, how long you have worked there, and describe the type of work you do.

_____

_____

2. Do you enjoy your job? Yes No
3. What do you like or dislike about it? _____

_____

_____

4. Have you ever been terminated or forced to resign from a job? Yes No

If yes, please explain: _____

_____

_____

5. Do you have a history of being disciplined (e.g., suspended, demoted, written up) at work? Yes No

If yes, please tell us the following details:

Job/company	Your story	The story of record	Outcome

6. Place an X in the box that best describes your work-related relationships:

Individual	Poor	Good	Excellent
Supervisors			
Co-workers			

7. Please list any job-related awards/commendations:
   a. _____
   b. _____
   c. _____

MILITARY SERVICE HISTORY

Please answer the following if you have a history of foreign or domestic military service.

1. In which branch of the military did/do you serve?_____
2. What are your dates of services?_____
3. Highest rank achieved? _____
4. If applicable, what type of discharge did you receive? _____
5. Please describe disciplinary history, if applicable: _____
6. Any problems with peers? Yes No If yes, please explain:

_____

_____

7. Any problems with senior ranking members or supervisors? Yes No If yes, please explain:

_____

_____

SUBSTANCE USE HISTORY

1. Please place an X in the box next to all the substances that you/the client have experimented with in your lifetime. In addition, the age of first use, whether the use is past or present, and if you or others think it is/was problematic:

Mark X if used	Type of substance	Age first used	Past or present use?	Problematic? (yes or no)
	Alcohol			
	Cannabis e.g., pot, hash			
	Heroin			
	Cocaine			
	Stimulants e.g., speed			
	Prescription pills e.g., Xanax, Oxycontin			
	Other substances: please list below			

2. Have you participated in formal substance abuse treatment? Yes No

If yes, please use the chart to provide details of each treatment experience:

Treatment Dates	Treatment Duration	Type of Therapist	Purpose	Setting			
				In Pt	Out Pt	IOP	Res

3. Please list any legal problems related to substance use, e.g., DUI, and the age of occurrence:

Problem/charge/citation	Age/year of occurrence

FAMILY HISTORY

Place an "X" in the box next to all that apply to your/the client's family history:

Mark X if applies	Problem	Please provide details, e.g., who and what
	Acute or chronic medical problems, e.g., cancer, heart disease, etc.	
	Mental health problems (note if treated/untreated or diagnosed/undiagnosed)	
	Drug or alcohol problems	
	Learning difficulties	
	Developmental delays, e.g., walking, talking, etc.	

RELATIONSHIP HISTORY

1. Below, please place an "X" to the right of the word that best describes your current relationship status:

single		married		divorced		Other:_____	

2. If you are currently married, please answer the following questions.
   a. How long have you been married?_____
   b. How many children has this marriage produced? None 1 2 3 4 5 6
   c. Do you or your spouse have children from other relationships? Yes No
   d. Are those children living with you? Yes No
      If yes, are they full-time or part-time residents? FT PT
   e. Please provide the name and age of each child that resides with you:
      i. _____ _____
      ii. _____ _____
      iii. _____ _____
      iv. _____ _____
3. Please use the scale to rate how satisfied you are with your current relationship:

   \- _____ +
   1 2 3 4 5 6 7 8 9 10
   Low satisfaction ---------->Average satisfaction ---------->High satisfaction

4. Use the chart to identify all that apply to your current relationship and who performs the behavior:

Relationship issue	Me	Spouse/ partner	Does not apply
Proven extramarital affairs			
Suspects extramarital affairs			
Verbal/emotional/psychological abuse			
Physical violence			
Threat of physical violence/intimidation			
Inappropriate/unwanted sexual behavior			
Hurts children			
Yells, screams			
Breaks/throws objects when angry			

5. Has your child (or children) witnessed arguments or fights? Yes No
6. Have you and/or your spouse/partner sought help for any of the above problems? Yes No
7. Which marriage is this for: You? 1st 2nd 3rd 4th
   Your spouse? 1st 2nd 3rd 4th

MENTAL STATUS ASSESSMENT

Using the scale below, please rate each of the following problem areas that have been present during the past year or have occurred prior to the past year if they clearly contribute to the reasons for seeking treatment.

0= No significant problem
1= Mild or transient
2= Moderate
3= Severe
4= Extreme
5= Catastrophic
9= Unknown or cannot categorize

0 1 2 3 4 5 9	Easily distracted
0 1 2 3 4 5 9	Does not follow rules of structured games
0 1 2 3 4 5 9	Difficulty organizing tasks
0 1 2 3 4 5 9	Shifts from one uncompleted task to another
0 1 2 3 4 5 9	Steals from family members and others
0 1 2 3 4 5 9	Tells lies
0 1 2 3 4 5 9	Truant from school
0 1 2 3 4 5 9	Destroys property of others
0 1 2 3 4 5 9	Cruel to animals
0 1 2 3 4 5 9	Loses temper
0 1 2 3 4 5 9	Defies or refuses requests made by adults/authority figures
0 1 2 3 4 5 9	Blames others for his/her mistakes
0 1 2 3 4 5 9	Angry and/or resentful
0 1 2 3 4 5 9	Swears and uses abusive language
0 1 2 3 4 5 9	Refuses to go to school
0 1 2 3 4 5 9	Physical complaints on school days
0 1 2 3 4 5 9	Self conscious
0 1 2 3 4 5 9	Tics or spasms
0 1 2 3 4 5 9	Problems with bowel control
0 1 2 3 4 5 9	Suicidal thoughts/attempts
0 1 2 3 4 5 9	Trouble getting along with same-age children
0 1 2 3 4 5 9	Withdraws into imaginary world
0 1 2 3 4 5 9	Cries
0 1 2 3 4 5 9	Problems remembering
0 1 2 3 4 5 9	Does not show emotion
0 1 2 3 4 5 9	Does not do homework

0 1 2 3 4 5 9	Talks excessively
0 1 2 3 4 5 9	Engages in potentially dangerous activities without considering the consequences
0 1 2 3 4 5 9	Does not complete tasks
0 1 2 3 4 5 9	Excessive or unrealistic worry about future events
0 1 2 3 4 5 9	Runs away from home
0 1 2 3 4 5 9	Sets fires
0 1 2 3 4 5 9	Destroys own property
0 1 2 3 4 5 9	Used a weapon in a fight
0 1 2 3 4 5 9	Initiates fights
0 1 2 3 4 5 9	Deliberately does things to annoy others
0 1 2 3 4 5 9	Touchy or easily annoyed by others
0 1 2 3 4 5 9	Is spiteful or vindictive
0 1 2 3 4 5 9	Worries about harms coming to parent or others
0 1 2 3 4 5 9	Resists separation from caretakers
0 1 2 3 4 5 9	Problems with wetting
0 1 2 3 4 5 9	Low energy level
0 1 2 3 4 5 9	Hurst self on purpose
0 1 2 3 4 5 9	Does not do chores
0 1 2 3 4 5 9	Displays inappropriate sexual behavior
0 1 2 3 4 5 9	Problems with speech
0 1 2 3 4 5 9	Mood swings
0 1 2 3 4 5 9	Sees/hears things that are not there
0 1 2 3 4 5 9	Over-active behavior
0 1 2 3 4 5 9	Problems with sleeping
0 1 2 3 4 5 9	Grades have declined from previous years
0 1 2 3 4 5 9	Lacks motivation

0 1 2 3 4 5 9	Eating problems
0 1 2 3 4 5 9	Poor school grades
0 1 2 3 4 5 9	Suspended or expelled from school
0 1 2 3 4 5 9	Suspected to or known to drink alcoholic beverages
0 1 2 3 4 5 9	Other:_____

0 1 2 3 4 5 9	No goals
0 1 2 3 4 5 9	Needs reassurance about a variety of things
0 1 2 3 4 5 9	Suspected or known to use drugs
0 1 2 3 4 5 9	Other:_____
0 1 2 3 4 5 9	Other:_____

PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS

Using the scale below, please rate each of the following problem areas that have been present during the past year or have occurred prior to the past year if they clearly contribute to the reasons for seeking treatment. Please specify the type of problem that applies.

0= No significant problem
1= Mild or transient
2= Moderate
3= Severe
4= Extreme
5= Catastrophic
9= Unknown or cannot categorize

0 1 2 3 4 5 9	**Problems with primary support group:**	Death of family member, separation, divorce, sexual or physical abuse, discord in the family with family members
0 1 2 3 4 5 9	**Problems related to social environment:**	Death or loss of a friend, living alone, discrimination, adjustment to life-cycle transition (e.g., leaving home, retirement)
0 1 2 3 4 5 9	**Educational problems:**	Unable to read, academic problems, discord with teachers or classmates
0 1 2 3 4 5 9	**Occupational problems:**	Unemployment, threat of job loss, stressful work environment/schedule, discord with boss or co-workers
0 1 2 3 4 5 9	**Housing problems:**	Homeless, unsafe neighborhood, discord with neighbors or landlord
0 1 2 3 4 5 9	**Economic problems:**	Not enough money to pay bills, food, and rent
0 1 2 3 4 5 9	**Problems with access to health care services:**	Inadequate health care, transportation to health care facilities unavailable, inadequate health insurance
0 1 2 3 4 5 9	**Problems related to interaction with the legal system/crime:**	Arrest, incarceration, litigation, victim of a crime
0 1 2 3 4 5 9	**Other psychosocial and environmental problems:**	Exposure to disasters; discord with non-family caregivers such as counselor, social worker, or physician; unavailability of social service agencies

Use this space for any additional information that didn't fit in spaces available on previous pages.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please stop here!

For OFFICE and STAFF USE ONLY:

Interview behavior:_____
Mood/Affect: _____
Orientation: _____ Speech: _____ Eye contact: _____
Insight: _____ Judgment: _____
Treatment/Interview Motivation: _____
Hallucinations: _____
_____
Delusions: _____
_____
Suicidality/Homicidality: _____
_____
Thought processes (goal-oriented, direct, linear): _____
Mannerisms: _____
IQ estimate: _____ Cognitive functioning: _____

DSM-IVR ASSESSMENT (PLEASE INCLUDE CODE)
AXIS I:
AXIS II:
AXIS III:
AXIS IV:
ASIS V:

Testing procedures: _____
_____
_____
_____
_____
_____

Preliminary recommendations: _____
_____
_____