Intake Assessment

Client Information

Last Name: First Name: Middle Initial:

Date of birth: Male: ___ Female: ___ Phone:

Current address:

City: State: Zip Code:

Email address:

Ok to leave phone message? Yes _____ No_____ Which number?

Ok to send mail? Yes ______ No _____

Ok to email? Yes _____ No_____

How did you hear about Journey Professional Counseling?

Marital History

Single/Never Married: _____ Married: _____ Separated: _____ Divorced:

If you are currently married, how long?	If you are currently living with someone how long?

How many times have you been married?

Please list your Children	Age	Relationship (Biological/Step/Adopted)	Currently lives with

Emergency Contact

Name of a person to contact in case of an emergency:

Address:

City: State: Zip Code:

Phone Number: Relationship:

Presenting Issues

Briefly discuss what brings you in today:

What would you like to be different?

Mental Status

Please check any of the following that describe how you have been feeling lately:

Sad ___ Anxious ___ Depressed ___ Frightened ___ Guilty ___ angry ___ Ashamed ___ Aggressive___ Resentful ___ Jealous ___ Hopeless ___ Helpless ___

Withdrawn ___ Tearful ___ Irritable ___ Confused ___ Extreme ups and downs ___

Describe any other feelings you have had:

What activities or functions do you participate in?

Do you participate in regular exercise? ___Yes ___ No	If yes, type of exercise:	Frequency:

Risk Assessment

Have you ever considered suicide in connection with your current problem?
Yes ______ No ______ If yes, please describe:

Have you ever considered suicide in the past? Yes _____ No _____

If yes, please describe:

Have you ever been physically violent? Yes _____ No _____

If yes, please describe:

Have you ever considered homicide? Yes _____ No _____

If yes, please describe:

Have you ever dealt with issues of self-harm (cutting, biting, burning, scratching, etc.)
Yes _____ No _____

If yes, please describe with dates:

Family History

How would you describe your current support network (family, friends, church, support groups, etc.)

Please check all information which applies to your biological parents

Father's Name:	**Mother's Name:**
___ Living	___ Living
___ Deceased	___ Deceased
___ Married	___ Married
___ Divorced	___ Divorced
___ Remarried _____ number of times	___ Remarried _____ number of times

Where does your father currently live?

Where does your mother currently live?

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real parents"? _____Yes _____No

If so whom and what is your relationship with that person?

Describe your relationship with your father while growing up:

Describe your relationship with your mother while growing up:

Siblings Name:	**Age**	**Relationship (natural, step, half, adopted)**

Briefly describe your relationship with your siblings while growing up:

Medical History

Name of Primary Care Provider:	Phone:
Address:	

It is often beneficial for us to converse with the client's physician to coordinate care. Do you give us consent to discuss your care with the physician listed above?
_____Yes _____No

Please sign consent here:	Date:

Please List your current medications below:

Current	Dosage/Frequency	Start Date	Purpose

Medications have been prescribed by:

Have you experienced any recent changes in sleeping or eating habits, or any unexplained weight loss or gain? Yes ___ No ___ If yes, please explain:

Do you ever restrict your food consumption or engage in purging? Yes ___ No ___
If yes, please discuss (include dates):

Have you ever been hospitalized for medical or psychiatric reasons? ___Yes ____No

Hospital	Month/Year	Reason

Have you ever seen a therapist before? Yes ____ No ____ If yes please explain (include dates, location, and therapist name):		
Do you use recreational drugs? _____Yes _____No If no, have you used drugs previously? ______Yes ______No		
When did you start?		
Type of drug(s)?	**How much?**	**How often?**
Do you drink alcohol? ___Yes ___No If no, have you used previously? ___Yes ___No		
When did you begin using alcohol?		
Type of alcohol	**How much?**	**How often?**
Do you smoke Cigarettes? Yes___ No___ If yes, how many smoked per day?		
Do you use other forms of tobacco? ___Yes ___No If yes what kind?		
Emotional Difficulty		
Describe any family problems which occurred while growing up relating to sexual, physical, or emotional abuse:		
Describe any family problems which occurred while growing up relating to alcohol and/or drug abuse:		
Describe any important medical history, chronic ailments, or other health problems you experienced:		

Describe any other health problems or important medical history about your immediate family or close family members including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent, etc) who have experienced depression, anxiety, or other emotional difficulties? If so please list:

Relative:	Please explain difficulties:

School & Work History

Did you experience any developmental, academic, or behavioral problems as a child or while in school, with peers, or teachers? Yes_____ No _____

If yes, please explain:

What was the last year of school completed?

If you did not complete High School, please explain:

Please list schools you are currently attending or have attended in the past

Are you currently attending school/GED classes? Yes _____ No _____

If yes, where?

Are you currently employed? Yes _____ No _____ If yes where?

If no, please Explain:

Please list your previous places of employment:

Legal History

Have you ever been arrested? Yes _____ No _____ If yes, please explain, including

Have you ever been on probation and/or parole? Yes _____ No _____ If yes, please explain, including when and why:

Have you ever been incarcerated? Yes _____ No _____ If yes, please explain, including when and why:

Social, Cultural, and Spiritual History

How would you describe your current support network (family, friends, church, support groups, etc.?):

How important is spirituality, or religion? Low_____ Medium: ______ High ______

Do you currently engage in spiritual activities? Yes ______ No ______ If yes, please explain:

What other functions or activities do you participate in?

What would you consider to be your strengths?

____

Client/Guardian Signature

____

Date