# Intake Assessment

**Today's date** ____________________________

Full Name: ____________________________________________________________________________

Address: ____________________________________________________ **Birthdate**: _________________

City: ___________________________________________________ State: ________ Zip: _________

Home Phone (_____)_________________________ Calls will be discreet, but please indicate any restrictions:

______________________________________________________________________________________

Employer: ____________________________________________________________________________

Work Phone: (_____)_________________________ Calls will be discreet, but please indicate any restrictions:

______________________________________________________________________________________

Who suggested you contact me? _____________________________________________________________

Please describe your education and any special training ___________________________________________

______________________________________________________________________________________

Your medical doctor or clinic: __________________________________ Phone: _____________________

Insurance Company__________________________________________ Deductible ___________________

Please list any significant health problems from your past or for which you currently receive treatment.

______________________________________________________________________________________

______________________________________________________________________________________

Are you currently taking any medications? __ Yes __ No If yes, please list: ____________________________

______________________________________________________________________________________

Have you had prior counseling elsewhere? __ Yes __ No If yes, please describe: ________________________

______________________________________________________________________________________

Have you ever been hospitalized for mental health reasons? __ Yes __ No If yes, when? __________________

Please list members of your family of origin and other important persons in your current living situation.

| NAME | AGE | RELATIONSHIP TO YOU | OCCUPATION |
|---|---|---|---|
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# Needs Assessment

The following is a list of **CONCERNS** that many people have. **CHECK** the box if you want help with a certain issue and then **CIRCLE** the extent to which it troubles you.

**KEY: 0 = “none” 1 = “some” 2 = “much” 3 = “very much” 4 = all the time”**

| Requesting Help For | Specific Concern | Extent to which it troubles you | Comments |
|---|---|---|---|
| ☐ | 1. Anxiety and tension ……………………………….… | 0…1…2…3…4 | ______ |
| ☐ | 2. Fears/worrying too much ……….….……………… | 0…1…2…3…4 | ______ |
| ☐ | 3. Dizziness or chest pains …………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 4. Health problems …………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 5. Chronic pain ………………………………………… | 0…1…2…3…4 | ______ |
| ☐ | 6. Breakup/loss of a relationship ………………………. | 0…1…2…3…4 | ______ |
| ☐ | 7. Relationship with a spouse/partner ……………………. | 0…1…2…3…4 | ______ |
| ☐ | 8. Relationship with family/parents/siblings …………….. | 0…1…2…3…4 | ______ |
| ☐ | 9. Communication skills …………………………………. | 0…1…2…3…4 | ______ |
| ☐ | 10. Dealing with anger …………………………………… | 0…1…2…3…4 | ______ |
| ☐ | 11. Tendency to be suspicious of others …………………. | 0…1…2…3…4 | ______ |
| ☐ | 12. Perfectionism/lack of acceptance of self …………….. | 0…1…2…3…4 | ______ |
| ☐ | 13. Critical/sarcastic toward others ………………………. | 0…1…2…3…4 | ______ |
| ☐ | 14. Thoughts of harming others ..………………………… | 0…1…2…3…4 | ______ |
| ☐ | 15. Loneliness/feeling isolated/not “fitting in”..…………. | 0…1…2…3…4 | ______ |
| ☐ | 16. Shyness/being ill at ease with people ………………… | 0…1…2…3…4 | ______ |
| ☐ | 17. Afraid of a close relationship …………………………. | 0…1…2…3…4 | ______ |
| ☐ | 18. Death of a friend or loved one ………………………… | 0…1…2…3…4 | ______ |
| ☐ | 19. Unhappy much of the time ……………………………. | 0…1…2…3…4 | ______ |
| ☐ | 20. Depression ……………………………………………. | 0…1…2…3…4 | ______ |
| ☐ | 21. Feeling unworthy or inferior …………………………. | 0…1…2…3…4 | ______ |
| ☐ | 22. Procrastination/difficulty getting motivated …………. | 0…1…2…3…4 | ______ |
| ☐ | 23. Difficulties with concentration …..…………………… | 0…1…2…3…4 | ______ |
| ☐ | 24. Sleep problems ……………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 25. Constant tiredness/lack of energy ……………………. | 0…1…2…3…4 | ______ |
| ☐ | 26. Thoughts of suicide ………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 27. Lack of purpose or meaning in life …………………... | 0…1…2…3…4 | ______ |
| ☐ | 28. Eating problems (any preoccupation with food) …….. | 0…1…2…3…4 | ______ |
| ☐ | 29. Bulimia (binge/purge cycle) …………………………. | 0…1…2…3…4 | ______ |
| ☐ | 30. Anorexia (limiting food intake, never thin enough) …. | 0…1…2…3…4 | ______ |
| ☐ | 31. Weight problems …………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 32. Physical appearance ………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 33. Physical handicap or disability ………………………. | 0…1…2…3…4 | ______ |
| ☐ | 34. Work-related problems ………………………………. | 0…1…2…3…4 | ______ |
| ☐ | 35. Career choices ……………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 36. Financial concerns …………………………………… | 0…1…2…3…4 | ______ |
| ☐ | 37. Drug or alcohol use ………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 38. Legal matters ………………………………………… | 0…1…2…3…4 | ______ |
| ☐ | 39. Sexually transmitted disease(s) ……………………… | 0…1…2…3…4 | ______ |
| ☐ | 40. Sexual orientation ……………………………………. | 0…1…2…3…4 | ______ |
| ☐ | 41. Sexual/intimacy problems ……………………………. | 0…1…2…3…4 | ______ |
| ☐ | 42. Physical or sexual abuse ……………………………… | 0…1…2…3…4 | ______ |
| ☐ | 43. Nightmares …………………………………………… | 0…1…2…3…4 | ______ |
| ☐ | 44. Hurting self (cutting, hitting oneself) ………………… | 0…1…2…3…4 | ______ |
| ☐ | 45. Headaches ……………………………………………. | 0…1…2…3…4 | ______ |
| ☐ | 46. Feeling unreal ………………………………………… | 0…1…2…3…4 | ______ |
| ☐ | 47. Unusual thoughts or beliefs ………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 48. Hearing things ……………………………………….. | 0…1…2…3…4 | ______ |
| ☐ | 49. Difficulties in making basic life decisions …………... | 0…1…2…3…4 | ______ |
| ☐ | 50. Other (please describe) ______________ | 0…1…2…3…4 | ______ |
| ☐ | 51. Other (describe) ______________ | 0…1…2…3…4 | ______ |

Please describe your reason(s) for seeking counseling at this time. Be sure to identify any situations for which you are particularly seeking help. ____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

Describe the ways that your concerns currently interfere with your personal and/or professional life.

____________________________________________________________

____________________________________________________________

What have you already tried to do about your concern(s)?

____________________________________________________________

____________________________________________________________

Please add any additional information that you feel may be useful: ________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

## CONFIDENTIALITY

I have a legal responsibility to protect the confidentiality of any information you share. That means that you can normally be certain that everything you say here, "stays here," between you and me. There are, however, some exceptions to confidentiality which are designed to protect you, me, and others in certain situations. These exceptions include:

1. If you make a serious threat to harm yourself or another person, the law requires me to protect you or that other person.
2. When there is information that leads to a reasonable suspicion of child abuse or abuse of a vulnerable adult, I may be required to report this.
3. If you are coming to me based on an order or recommendation from a court, the court normally expects a report from me. When court-ordered, or when required in conformity to state or federal laws, information regarding our work together may be released.
4. If you sign a release of information, such as for your insurance company.

IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE, PLEASE ASK ME PRIOR TO SIGNING.

**I have read the above statement and I agree to participate in counseling under the stated conditions.**

**Signed** ______________________________________________ **Date** ____________________

*Thank you for completing this form. The information you provide is valuable in assisting with your treatment.*