

Woodlands Family Institute P.C.
Melissa Engel, LPC-Intern, NCC
Intake Assessment Form

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services

- ___ Anger management ___ Anxiety ___ Coping ___ Depression
 ___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns
 ___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs
 ___ Other mental health concerns (specify): _____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Information about family/significant others (past and present): _____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|-------------------------|-------------------------|----------------------------|
| ___ Aggression | ___ Elevated mood | ___ Phobias/fears |
| ___ Alcohol dependence | ___ Fatigue | ___ Recurring thoughts |
| ___ Anger | ___ Gambling | ___ Sexual addiction |
| ___ Antisocial behavior | ___ Hallucinations | ___ Sexual difficulties |
| ___ Anxiety | ___ Heart palpitations | ___ Sick often |
| ___ Avoiding people | ___ High blood pressure | ___ Sleeping problems |
| ___ Chest pain | ___ Hopelessness | ___ Speech problems |
| ___ Cyber addiction | ___ Impulsivity | ___ Suicidal thoughts |
| ___ Depression | ___ Irritability | ___ Thoughts disorganized |
| ___ Disorientation | ___ Judgment errors | ___ Trembling |
| ___ Distractibility | ___ Loneliness | ___ Withdrawing |
| ___ Dizziness | ___ Memory impairment | ___ Worrying |
| ___ Drug dependence | ___ Mood shifts | ___ Other (specify): _____ |
| ___ Eating disorder | ___ Panic attacks | _____ |

PARENTAL INFORMATION

Parents legally married Mother remarried: Number of times: _____
 Parents have been separated Father remarried: Number of times: _____
 Parents divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? Yes No

If Yes, please describe: _____

Has there been history of child abuse? Yes No

If Yes, which type(s)? Sexual Physical Verbal

If Yes, the abuse was as a: Victim Perpetrator

Other childhood issues: Neglect Inadequate nutrition Other (please specify): _____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower
 Friendly Leader Outgoing Shy/withdrawn Submissive
 Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? Yes No

If Yes, describe: _____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe: _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

If Yes, describe: _____

LEGAL

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

PAST HISTORY

DWI, DUI, etc.: ____ Yes ____ No

Criminal involvement: ____ Yes ____ No

Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes ____ No

____ High school grad/GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training: _____

EMPLOYMENT

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe): _____

MILITARY

Military experience? ____ Yes ____ No

Combat experience? ____ Yes ____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL/PHYSICAL HEALTH

List any significant past health concerns: _____

List any current health concerns: _____

List any recent health or physical changes: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ___ Yes ___ No

If Yes, describe: _____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

- ___ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level
___ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	_____
Heroin /Opiates	_____	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____	_____	_____

Substance of preference

1. _____ 3. _____
 2. _____ 4. _____

Describe when and where you typically use substances: _____

Reason(s) for use:

- ___ Addicted ___ Build confidence ___ Escape ___ Self-medication
 ___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ___ No If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Have drugs or alcohol created a problem for your job? ___ Yes ___ No

If Yes, describe: _____