Intake Assessment

Demographics

Date: 04/28/2015 **Admit Date:** **Time Begun:** 8:16am **Time Ended:**

Presenting Problem:

Client Name: John Doe **Patient ID#:** 1

Address: ,

Telephone (Home): **Cell:**

Date of Birth: **Age:** **Sex:**

Email:

Social Security #:

Placement Information

What specific events precipitated the decision to seek treatment?

What are your specific goals regarding treatment?

What are the client's strengths (intellectually, artistically, socially, physically, etc.)?

What are the client's weaknesses (intellectually, artistically, socially, physically, etc.)?

Please describe the client's experience with the outdoors and other physical activities:

Any plans for future placement?

Educational Information

What is the highest level of education completed?

Currently attending school? ○ No ◉ Yes

Name of Current School:

Has the client ever been assessed for learning disabilities? ○ No ◉ Yes

If Yes, please describe:

Has the applicant received any medical or educational treatment for learning disabilities? ○ No ◉ Yes

If Yes, please describe:

If there have been no learning disability assessments, are there any concerns this may be an issue?

○ No ◉ Yes

If Yes, please explain:

Family Information

Current marital status:

Number of children?

Please list name, age, current residence, and health of each sibling:

Name	Age	Gender	Current residence	Health

Chief Complaint

Reason for Referral: Chief complaint and symptoms (Please be very specific including issues at home and work as well as any symptoms noticed such as mood changes, etc.)

Placement/Intervention History

Have you ever been given a psychiatric diagnosis? ○ No ◉ Yes

If Yes, diagnosis:

When?

Have you ever been treated for a substance abuse issue? ○ No ◉ Yes

Location	Dates of Treatment	Level of Care	Length of Stay	Length of Sobriety	Outcome: If relapsed, why?

Have you received mental health services or are you currently receiving service? ○ No ◉ Yes

Location	Date of Treatment	Level of Care	Duration of Treatment	Diagnosis or Reason in Treatment

Psychological Testing Has the client had any psychological testing? ○ No ◉ Yes

If Yes, please describe (include date/reason):

***Note: Please fax/email/mail all previous testing from the last 3 years as part of this application.**

Psychological History

Please describe any major events the client has struggled with (divorce, moving, birth of child, loss, death, abuse, illness, etc.) Please include the date the event occurred:

Anger Describe the way(s) in which the client expresses anger:

Has the client had any physical confrontations in the home or with others? ○ No ◉ Yes

If Yes, please describe:

Has the client ever intentionally hurt him/herself? ○ No ◉ Yes

If Yes, please describe (include date/reason):

Suicidality Has the client ever had thoughts of suicide, made a plan, or attempted suicide? ○ No ◉ Yes

If Yes, please describe (specify date/reason):

Sexual Activity Please describe any risky, aggressive or inappropriate sexual behaviors (promiscuity, unprotected sex, perpetrating, deviance, etc.)?

Mood Issues Does the client exhibit signs of anxiety, depression, mood swings, etc.? ○ No ◉ Yes

If Yes, please describe:

Obsessions/Compulsions Does the client experience recurrent thoughts or repeated behaviors that he/she cannot control? ○ No ◉ Yes

If Yes, please describe in detail including dates:

Lying, Stealing, Vandalism, Dealing Drugs, Criminal Activity ○ No ◉ Yes

If Yes, please describe in detail including dates:

Unusual Behaviors (Check all that apply)

☐ **Delusions** ☐ **Hallucinations** ☐ **Nightmares**

☐ **Paranoid Thinking** ☐ **Tics** ☐ **Stuttering**

Please describe in detail including dates:

Isolation Does the client have problems with isolation? ○ No ◉ Yes

If Yes, please describe in detail:

Substance-Related Issues Does the applicant have any alcohol, substance and/or dependency related issues? ○ No ◉ Yes

If Yes, describe when you first noticed substance use and the choice of substance, usage patterns/frequency and how administered. Please include cigarette use:

Family History of Drug or Alcohol Abuse? ○ No ◉ Yes

If Yes, please describe (including who/relationship, problem area, current status):

Family History of Mental Illness (e.g. depression, anxiety, etc.)? ○ No ◉ Yes

If Yes, please describe (including who/relationship, problem area, current status):

Other Addictive Patterns (e.g. computer games, T.V., phone, internet, sex, gambling)? ○ No ◉ Yes

If Yes, please describe:

Legal Problems? ○ No ◉ Yes

If Yes, please list any charges, convictions, misdemeanors, felonies, probation and current legal

Charges	Date	Court Date	Result of Charges (Indicate if they are pending)

Medical Information

Do you have a Family Doctor? ○ No ◉ Yes

Family Doctor:

Telephone # of Doctor:

Address of

Date of last

Family Dentist:

Does the applicant wear: ☐ **Contacts** ☐ **Glasses**

Please list any surgeries, serious illness and/or hospitalizations. Please indicate date/event:

Facility	City/State	Date(s) Treated	Length of Stay	Reason

Please list any prescription and/or over-the-counter medications the client is currently taking and the reasons for each (include dosage, prescribing physician/phone):

Medication	Dose & Frequency	Route	Length of Time	Last Dose, Date & Time	Prescribing Physician	Reason Prescribed	Do you believe the medication is effective?

Are there any known side effects of the medication? ○ No ◉ Yes

If Yes, please describe:

Please list previous history of medications (include name of medication, dosage, reason, prescribing physician):

Medication	Dose & Frequency	Route	Length of Time	Last Dose, Date & Time	Prescribing Physician	Reason Discontinued	Do you believe the medication was effective?

Is the client currently taking any vitamins or supplements? ○ No ◉ Yes

If Yes, please describe:

Does the client currently get exercise? ○ No ◉ Yes

If Yes, please describe:

Describe any pertinent medical/physical information that might inhibit physical activity:

Does the applicant have any dietary restrictions? ○ No ◉ Yes

If Yes, please describe:

Does the client currently have or ever had any of the following? (Check box if, Yes)

☐ **Allergies**	☐ **Anaphylactic shock**	☐ **Anemia**
☐ **Ankle problem**	☐ **Anorexia/bulimia**	☐ **Appendicitis**
☐ **Arm problem**	☐ **Arthritis**	☐ **Asthma**
☐ **Back problems**	☐ **Bedwetting**	☐ **Bladder/kidney problems/infections**
☐ **Bleeding disorder**	☐ **Bone condition**	☐ **Bowel problems**
☐ **Broken bones**	☐ **Cancer**	☐ **Chest pains**
☐ **Chronic cough**	☐ **Circulation issues**	☐ **Colds - frequent**
☐ **Constipation**	☐ **Cysts/tumors**	☐ **Dermatitis**
☐ **Diabetes I or II**	☐ **Diarrhea**	☐ **Difficulty walking/lifting**
☐ **Ear infections**	☐ **Endocrine problems**	☐ **Excessive sweating**
☐ **Fainting/dizziness**	☐ **Family history of heart disease**	☐ **Foot problem**
☐ **Frequent sore throats**	☐ **Frequent heartburn**	☐ **Frequent muscle cramps**
☐ **HIV/AIDS**	☐ **Frostbite**	☐ **Gas/bloating**
☐ **Frequent shortness of breath**	☐ **Head traumas**	☐ **Headaches/migraines**
☐ **Hearing impairment**	☐ **Heart problems/murmurs**	☐ **Hepatitis A B or C**
☐ **Hernia**	☐ **High blood pressure**	☐ **Hypoglycemia**
☐ **Intolerance to cold**	☐ **Intolerance to heat**	☐ **Irregular heartbeat**
☐ **Joint injuries**	☐ **Kidney problems**	☐ **Knee problem**
☐ **Leg problem**	☐ **Medical equipment/devices**	☐ **Lung infections**
☐ **Liver problems**	☐ **Meningitis**	☐ **Menstrual problems/heavy bleeding**
☐ **Mononucleosis**	☐ **Motion sickness**	☐ **Obesity**
☐ **Other**	☐ **PMS - severe**	☐ **Pneumonia/bronchitis**
☐ **Pregnancy**	☐ **Recurrent injury/surgery**	☐ **STDs**
☐ **Scoliosis**	☐ **Seizures/epilepsy**	☐ **Shoulder problem**
☐ **Skin diseases/problems**	☐ **Sleepwalking**	☐ **TB - positive test**
☐ **TB - recent exposure**	☐ **TB - Tuberculosis**	☐ **Thyroid problems**
☐ **Ulcers**	☐ **Unexpected weight loss**	☐ **Urination problem**

Please describe in detail any checked items:

Immunizations: Is the client up-to-date on immunizations? ◉ No ○ Yes

Date of Last Immunization:

Tetanus/Diphtheria:

Measles, Mumps, Rubella:

Hepatitis

Polio:

Allergies/Asthma:

Lists all allergies (food, medication, grasses, etc.), and the reaction:

	Allergy	Reaction
Medication Allergy		
Food Allergy		
Environmental Allergy		

Does the client carry an inhaler or epinephrine pen? ○ No ◉ Yes

Please list name/type of

Has the client ever been hospitalized for allergies/asthma? ○ No ◉ Yes

If Yes, please describe (include date/reason):

Family Medical History: Please list any pertinent medical history in the client's family:

Contact Signatures

Treatment Team Signatures