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Clinical Intake Assessment

Name: _____ Date of Birth: _____ Age: _____

Current Complaints: _____

_____

Symptoms: _____

_____

Goals: _____

_____

Current Stressors: _____

_____

HISTORICAL SECTION

Cultural Identification

A. What is your ethnicity?
B. Were your parents immigrants?
C. What is your religious identification?
D. What is your primary language spoken?
    a. Do you speak any other languages? Yes ☐ No ☐
E. Please describe other cultural considerations: _____

_____

Family/Childhood/Developmental:

1. What was your place of birth? _____
2. Were there any pregnancy complications? Yes ☐ No ☐
3. Did you have any problems with meeting developmental milestones (talking, crawling, walking)? Yes ☐ No ☐

4. Please describe you family composition in the home during childhood:
   a. Were you raised by both parents? Yes ☐ No ☐
   b. Who raised you?
   c. Were you ever placed outside the home (foster care, etc.?) Yes ☐ No ☐
5. Please describe your mother:
   a. In a few words, what is/was the quality of your relationship with your mother?

   b. What is/was her occupation?
   c. How did she discipline you as a child/what was her style?
   d. Do you have current contact with her? Yes ☐ No ☐
6. Please describe your father:
   a. In a few words, what is/was the quality of your relationship with your father?

   b. What is/was his occupation?
   c. How did he discipline you as a child/what was his style?
   d. Do you have current contact with him? Yes ☐ No ☐
7. Please describe your siblings:
   a. How many siblings do you have?
   b. Where do you fit in the line in terms birth order?

   c. In a few words, what is/was the quality of your relationship with your siblings?

   d. What are their occupations?
   e. Do you have current contact with them? Yes ☐ No ☐
8. Did you have any other significant figures in childhood such as extended family, teachers, neighbors that influenced your childhood? Yes ☐ No ☐
9. Did anything happen in your life that you view as important to shaping your life?
   Yes No
10. Did you make friends easily? Yes ☐ No ☐
11. Did you have a best friend? Yes ☐ No ☐
12. Do you have long term friends? Yes ☐ No ☐
13. Were you ever bullied as a child? Yes ☐ No ☐

14. Did you experience any traumatic experiences in your childhood?
    i. Physical abuse? Yes ☐ No ☐
    ii. Emotional abuse? Yes ☐ No ☐
    iii. Sexual abuse? Yes ☐ No ☐
    iv. Neglect? Yes ☐ No ☐
    v. Loss? Yes ☐ No ☐
    vi. Food insecurity? Yes ☐ No ☐
    vii. Homelessness? Yes ☐ No ☐
15. Did you experience any of these traumas as an adult? Yes ☐ No ☐

Education History:

16. What was your favorite/worst subjects in school? Favorite _____ Worst _____
17. What did you want to be when you grew up?
18. Did your aspirations change over time? Yes ☐ No ☐
19. What was your classroom "identity" (i.e., Class clown, loner, popular, achiever, rebellious)?
20. Were you into any extracurricular activities? Yes ☐ No ☐
21. Did you have any difficulty with focusing in school? Yes ☐ No ☐
22. Did you have difficulty with staying seated? Yes ☐ No ☐
23. Did you have difficulty doing homework? Yes ☐ No ☐
24. What is the highest level of education you have completed?
25. Please describe your education history:
    i. Were you ever in Special/Gifted education? Yes ☐ No ☐
    ii. Did you have an Individualized Education Plan (IEP)? Yes ☐ No ☐
        i. If yes, how old were you? _____
    iii. Do you have any diagnosed Learning disability? Yes ☐ No ☐
        i. If yes, what disability? _____
        ii. If yes, how old were you when you were diagnosed? _____
    iv. If applicable, did you have cognitive/intelligence testing in school?
        Yes ☐ No ☐ Not applicable ☐
    v. If applicable, did you see improvement with services?
        Yes ☐ No ☐ Not applicable ☐
    vi. Did you ever feel bored using educational materials? Yes ☐ No ☐

26. Were you ever suspended or expelled from school? Yes ☐ No ☐
27. Did you ever get into fights while in school? Yes ☐ No ☐
28. Did you ever skip classes? Yes ☐ No ☐
29. Did you ever cheat in school? Yes ☐ No ☐
30. Did you ever use drugs or alcohol on school premises? Yes ☐ No ☐

Employment History:

31. What kind of employment have you had in the past?

_____

32. How did you tend to find work? _____
33. Why did you tend to leave? _____
34. What has been your longest period of employment? _____
35. Have you ever had problems with an employer/supervisor? Yes ☐ No ☐
    i. If yes, what issues have tended to cause conflict in the past?

    _____
36. Have you ever been fired or quit without notice? Yes ☐ No ☐

Relationship History:

37. How many long-term romantic relationships have you had (3+ months)? _____
    i. In a few words, please describe the quality of past relationships:

    _____
    ii. What has been the reasons for relationships ending in the past?

    _____
    iii. What has been the quality of the relationship after break-up?

    _____
38. Have you ever experienced domestic violence? Yes ☐ No ☐
39. Are you married or have a significant other? Yes ☐ No ☐
40. Do you have any children? Yes ☐ No ☐
    i. If yes, please describe your relationship with their mother/father:
    ii. If yes, what has it been like for you to be a parent?

Medical History:

41. Do you have any chronic medical conditions? Yes ☐ No ☐

If yes, please list such conditions below:

i. _____

ii. _____

iii. _____

42. Have you had any major surgeries? Yes ☐ No ☐

43. Have you had any major physical traumas? Yes ☐ No ☐

44. Have you had any head injuries that resulted in a loss of consciousness?

Yes ☐ No ☐

i. If yes, how do you think the injury impacted your functioning?

_____

ii. If yes, have you had any neuropsychological testing completed?

Yes ☐ No ☐

Substance Use History:

45. Please indicate if you have a history of using any of the following substances:

a. Alcohol Yes ☐ No ☐

b. Caffeine Yes ☐ No ☐

c. Tobacco Yes ☐ No ☐

d. Cannabis Yes ☐ No ☐

e. Stimulants (i.e., Cocaine, Ritalin, amphetamine) Yes ☐ No ☐

f. Opioids (i.e., heroin, Norco, etc.) Yes ☐ No ☐

g. Hallucinogens (i.e., psylocibin mushrooms, etc.) Yes ☐ No ☐

h. Inhalants Yes ☐ No ☐

i. Sedatives Yes ☐ No ☐

j. Hypnotics Yes ☐ No ☐

k. Anxiolytics (i.e., benzos, etc.) Yes ☐ No ☐

46. If you marked yes for any of the above, did you experience any social, occupational, or legal problems associated with using this substance? Yes ☐ No ☐

47. Do you have a family history of substance abuse? Yes ☐ No ☐

48. Have you ever been in substance recovery treatment? Yes ☐ No ☐

Psychiatric History:

49. Do you have a history of mental health treatment? Yes ☐ No ☐
    i. If yes, how old were you? _____
    ii. If yes, what prompted it? _____
    _____
    iii. If yes, what was your diagnosis? _____
    iv. If yes, what were your symptoms? _____
    _____
    v. If yes, were you prescribed medications? Yes ☐ No ☐
    vi. If yes, was follow-up care recommended? Yes ☐ No ☐
50. Do you have any previous psychiatric hospitalizations? Yes ☐ No ☐
    i. If yes, how old were you? _____
    ii. If yes, what was your diagnosis? _____
    iii. If yes, were you prescribed medications? Yes ☐ No ☐
    iv. If yes, was what were your symptoms? _____
51. Do you have any family history of psychiatric problems? Yes ☐ No ☐
    i. If yes, who in your family had a psychiatric problem: _____
    ii. If yes, what was his/her diagnosis?
52. Have you ever had thoughts of wanting to die or end your life? Yes ☐ No ☐
    i. If yes, have you ever tried to commit suicide? Yes ☐ No ☐
    ii. If yes, have you ever been hospitalized for suicidal ideation? Yes ☐ No ☐
    iii. If yes, have you ever been hospitalized for suicide attempt? Yes ☐ No ☐
53. Have you ever hurt yourself without the intention of death (i.e., cutting, burning, choking yourself to not feel pain, etc.) Yes ☐ No ☐
54. Have you ever had thoughts of wanting to harm someone else? Yes ☐ No ☐
55. Do you have a history of having problems with any of the following behaviors:
    i. Compulsive gambling Yes ☐ No ☐
    ii. Overeating Yes ☐ No ☐
    iii. Restricted eating Yes ☐ No ☐
    iv. Obsessive Cleaning Yes ☐ No ☐
    v. Stealing Yes ☐ No ☐
    vi. Excessive sexual appetite Yes ☐ No ☐

56. Please indicate whether you are currently experiencing any problems listed below:

a) Poor sleep	Yes ☐	No ☐
b) Poor appetite	Yes ☐	No ☐
c) Change in weight	Yes ☐	No ☐
d) Fatigue	Yes ☐	No ☐
e) Low energy level	Yes ☐	No ☐
f) Depressed mood	Yes ☐	No ☐
g) Feeling Hopeless	Yes ☐	No ☐
h) Feelings of guilt	Yes ☐	No ☐
i) Less interest in fun activities	Yes ☐	No ☐
j) Feeling Nervous/anxious	Yes ☐	No ☐
k) Panic attacks	Yes ☐	No ☐
l) Mood swings	Yes ☐	No ☐
m) Racing thoughts	Yes ☐	No ☐
n) Persistent fear or worry	Yes ☐	No ☐
o) Elevated mood	Yes ☐	No ☐
p) Hyperactivity	Yes ☐	No ☐
q) Attention/concentration/easily distracted	Yes ☐	No ☐
r) Hallucinations	Yes ☐	No ☐
s) Paranoia	Yes ☐	No ☐
t) Short term memory	Yes ☐	No ☐
u) Long Term memory	Yes ☐	No ☐
v) Body aches or pains	Yes ☐	No ☐
w) Consistent gastrointestinal issues	Yes ☐	No ☐
x) Feeling easily startled	Yes ☐	No ☐
y) Feeling unsafe	Yes ☐	No ☐
z) Engaging in high-risk behavior	Yes ☐	No ☐

Thank you for taking the time to complete this intake form. We look forward to assisting you.

Signature: _____

Printed Name: _____ Date: _____