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INTAKE EVALUATION

To be completed by client

Identifying Information

Client's Name: ____ Today's Date: __________________

Partner's Name (if being seen as a couple): ____

Address:____ City, State, Zip: ____________________________

Telephone(s): Home: ______________ Client (Work): ______________ Partner (Work): ______________

May we leave a message for you at home? Yes or No: _____________

May we leave a message at work? Yes or No: _____________

Gender: M _____ F ______ Age: ________ Birth Date: _______________ Marital Status: _____________

Others living in the home (Include name, birthdate, and relationship to client for each):

____, ____

____, ____

Education: Self: ________________________________ Partner: ________________________________

Occupation: Self: _______________________________ Partner: ________________________________

Client's Employer: ____

Social Security (ID) Number: Self: ____________________ Partner (Optional): ________________________

Emergency Contact: ______________________________________ Phone: ___________________________

Referred by: ____

Insurance Information

Name of insured: ____________________________________ Insured date of birth: __________________

Address of insured person: ______________________________ City, State, Zip: _______________________

Relationship of client to insured person: ________________________________

Employer of insured person: ____

Insurance company: ___________________________________ Phone: ______________________________

Insurance company address: ____________________________ City, State, Zip: ______________________

Insurance identification number: _________________________ Group number: _______________________

Secondary insurance: __________________________________ Phone: ______________________________

Name of secondary insured: _____________________________ Date of Birth: _______________________

Secondary company address: ____________________________ City, State, Zip: ______________________

Secondary identification number: ________________________ Group number: _______________________

Patient or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signature: ____ Date: ______________________

Client Name: ___________________________________

Presenting Problem

Describe the problem that brought you here today:

Goals for treatment:

Check any of the symptoms that you are having:

Symptom		Symptom	
Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feeling of extreme happiness		Change in sexual interest or function	
Trouble performing your job		Problems getting along with friends or family	
Lack of enjoyment of usual activities		Feeling stressed	
Self-esteem problem		Easily irritated	
Perfectionism		Feeling guilty	
Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts about hurting yourself or others		Thoughts about killing yourself or others	
Anxiety		Feeling tense/uptight	

(This space reserved for additional comments by clinician)

History of Treatment

Have you ever been in counseling before?		Yes:	No:
If yes:			
When did you have counseling?	Date(s):		
Who did you see?	Name:		
Explain what happened:			
When did you have counseling?	Date(s):		
Who did you see?	Name:		
Explain what happened:			

Medical Information

Have you seen a doctor within the past year?	Yes:	No:
Why have you seen a doctor?		
Who is your doctor? Phone:		
Are you taking any kind of medication (prescription or over-the-counter)?	Yes:	No:
Please list the medicines that you are taking:		
Do you have allergies to anything?	Yes:	No:
Please describe allergy problems that you may have:		

Substance Use History

	Current	Past	No
Do you use/have you used tobacco (any form)?			
Do you use/have you used alcohol?			
Do you use/have you used caffeine (any form, including cola drinks)?			
Do you use/have you used recreational drugs?			