Rhonda **Andrews** LCSW
Individual, Child & Family Therapist

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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: _____

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:

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?			