Adult Intake Assessment Form

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Part I: Demographic Information

Client's Information

•**Date:**

•**Full Name (First, Middle, Last):**

•**Preferred Name:**

•**Date of Birth:**

•**Age:**

•**Address:** [Street, City, State, Zip]:

•**Phone Number:**

•**Email Address:**

•**Ethnicity/Race:** [e.g., Hispanic/Latino, Not Hispanic/Latino, American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, White, Other, Decline to state]:

•**Living Situation: Who lives in your household?** [List names and relationships]

•**Emergency Contact**

•**Full Name:**

•**Relationship to Client:**

•**Phone Number:**

Part II: Reason for Seeking Services

•**What are your main reasons for seeking therapy at this time?**

•**When did you first start feeling this way?**

•**Have there been any major life changes or stressful events recently?** (e.g., family changes, death, divorce, alien abduction, etc?):

•**What are your hopes for how therapy can help you?**

Is there anything about therapy that scares you or makes you nervous?

Part III: Presenting Concerns and Symptoms

Emotional and Behavioral Symptoms

•***Instructions:*** *Please rate how often you have experienced the following symptoms over the past two weeks.*

•(0) Not at all, (1) Several days, (2) More than half the days, (3) Nearly every day

•**Little interest or pleasure in doing things:** (0) (1) (2) (3)

•**Feeling down, depressed, irritable, or hopeless:** (0) (1) (2) (3)

•**Trouble falling/staying asleep, or sleeping too much:** (0) (1) (2) (3)

•**Feeling tired or having little energy:** (0) (1) (2) (3)

•**Poor appetite, weight loss, or overeating:** (0) (1) (2) (3)

•**Feeling bad about yourself, or feeling like a failure:** (0) (1) (2) (3)

•**Trouble concentrating on things:** (0) (1) (2) (3)

•**Feeling nervous, anxious, or on edge:** (0) (1) (2) (3)

•**Not being able to stop or control worrying:** (0) (1) (2) (3)

•**Feeling restless or fidgety:** (0) (1) (2) (3)

•**Becoming easily annoyed or irritable:** (0) (1) (2) (3)

•**Feelings of panic or intense fear:** (0) (1) (2) (3)

•**Increased anger or outbursts:** (0) (1) (2) (3)

•**Unusual thoughts or behaviors:** (0) (1) (2) (3)

•**Elaborate a bit about any of the above that you need to tell me:**

Part IV: Safety Assessment

•Have you had thoughts of harming yourself?

•☐Yes ☐No

•Have you had thoughts of ending your life?

•☐Yes ☐No

•Have you ever attempted suicide?

•☐Yes ☐No

•If you answered "yes" to any of the above, please provide details:

•Do you have any thoughts of harming others?

•☐Yes ☐No

•Have you ever harmed someone else intentionally?

•☐Yes ☐No

•If you answered "yes" to any of the above, please provide details:

•Have you ever been the victim of abuse or neglect?

•☐Yes ☐No

•If you answered "yes," what was the nature of the abuse or neglect?

Part V: Background and History

Mental Health and Treatment History

•**Have you ever received a mental health diagnosis?** If so, what was it?

•**Have you been in therapy or counseling before?** What was helpful or unhelpful?

•**Have you ever been hospitalized for a mental health concern?**

•**Do any of your family members have a history of mental health issues? If so, please state relationship to and diagnosis:**

Physical Health and Development

•**Do you have any current or past medical conditions?**

•**Are you taking any prescription or over-the-counter medications? If so list medication names and dosage:**

•**How would you describe your sleep patterns?**

•**How would you describe your appetite and eating habits?**

•**Describe your current level of physical activity.**

Married, single, separated, divorced?

Happy with your sex life?

Substance Use

•**Do you use alcohol, cannabis, tobacco, or other substances?** If so which substances and how often?

•**Have you ever had concerns about your substance use?**

Work and Social Life

•**What is your current occupation or situation?**

•**How would you describe your performance in your career?**

•**Are you satisfied with your work life?**

•**Are you satisfied with your social life?**

•**Are you satisfied with your family life?**

•**Do you have a strong support system of friends, family, or other adults?**

Who do you turn to most for help and emotional support?

Are you generally comfortable talking about your ideas and feelings or does that feel uncomfortable to you?

What helps you feel most comfortable when you meet someone new?

Do you see yourself as a leader or a follower? Popular, unpopular, Introvert/extrovert or more in between?

Part VI: Strengths and Coping

•What are some of your greatest strengths? (Give me five, please. Dig deep and don't be modest.)

•What do you do for fun?

•When you feel overwhelmed, what helps you cope?

Do you have a religious or spiritual belief that is important to you? If so, can you please describe it briefly:

•Is there anything else you want me to know about you?

Can you lick your elbow or roll your tongue? (Just curious)

Any other special talents or things you love?

Part VII: Consent and Signature (You made it to the end!)

•**Consent to Treatment:** The client understands the purpose of this assessment and consents to participate in mental health services.

•**Confidentiality:** The client has received information regarding their rights to confidentiality and its limits. We cover this in the first session. (Fee disclosure, Duty to report abuse or imminent harm to self or others including: children, the elderly and those with diminished capacity).

•Assessment session cost: $150

•Subsequent session cost: $100

•Other services: billed at $50 per half hour

•Duration of treatment is at client and parent's discretion.

•**Client Signature: _____Date: _____**

•**Assessing Professional Signature: _____ Date: _____**