Adult Intake Assessment

Name: ______________________________________ **Date:**_____________________

Primary Concern:

Please describe the concern(s) that brought you to see me:___________________________________

____

____

Treatment:

Have you/client ever received counseling/mental health treatment before? _____ yes ______ no

If yes, please describe when and for what? ____

____

____

If yes, was it a positive or negative experience and why? _____________________________________

____

Have you/client ever taken any medications for psychiatric or emotional concerns? ____ yes ____ no

If yes, please describe when, which medications, the condition, and the results: __________________

____

____

____

Relationships with your family of origin. Please describe the following:

Your/client's parents' relationship with each other:____

____

____

Your/client's relationship with each parent: ____

____

____

____

Any experience of divorce, separation or abandonment by a parent(s):___________________________

____

____

Your/client's parents' physical health problems, alcohol/drug use, and mental or emotional difficulties:

____

____

____

Your/client's relationship with your sibling(s), in the past and present:___________________________

____

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____

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Abuse History: ____ I/client have/has not experienced any abuse (physical, sexual, or emotional)
If you/client have/has experienced any emotional, physical, sexual abuse or neglect by anyone in your life, please describe the following - by whom, when, kind of abuse.

____
____
____

Whom did you/client tell and were there any consequences of telling? ______________________________
____
____
____

What were the effects of the abuse on you/client? ____
____
____

Additional comments: ____
____

Present Relationships:
What is your/client's relationship like with your present spouse/partner/romantic other?__________________
____
____
____

How many children, ages, biological, adopted, step, etc.?______________________________________
____
____

Describe your relationship with each of your children:____
____
____
____

Substance Use: _____ I/Client do/does not drink alcohol, use/abuse drugs, or use tobacco products
Please provide information about your/client's use of drugs and alcohol, including how often you drink/use, how much you drink/use, their typical effects on you/client:_____________________________________
____
____

Have you ever felt the need to cut down on your/client's drinking? _____ yes _____ no
Have you ever felt annoyed by criticism of your/client's drinking? _____ yes _____ no
Have you ever felt guilty about your/client's drinking? _____ yes _____ no
Have you ever taken a morning "eye-opener"? _____ yes _____ no
Hour much beer, wine, liquor to you consume each week, on average? ____________________________
____

How much tobacco do you smoke or chew each week? ____
Which drugs have you used in the last 10 years?____
____

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Have you ever used prescribed drugs other than as prescribed or struggled to stop using them? ___yes ___ no

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Legal History:

Are you currently involved with the court (Family, Civil, Criminal) or are you going to be___yes ___no

If yes, please explain: ____

____

____

Do you have an attorney? ___ yes ___ no If yes, attorney's name: ______________________

Firm:______________________________ Phone: ______________________

Do you anticipate needing testimony? ____ yes _____ no If yes, please explain______________

____

Are you required by a court or legal authority to have this appointment?____ yes ____ no

If yes, please explain: ____

____

Do you have any history of criminal activity, domestic abuse, child maltreatment, or civil or federal charges? ____ yes ____ no If yes, please explain:______________________________

____

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Other:

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here: ________________

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