Woodlands Family Institute P.C.

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Intake Assessment Form

Client's name: _____ Date: _____

Gender: ____ F ____ M Date of birth: _____ Age: _____

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify): _____

COUNSELING/PRIOR TREATMENT HISTORY

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric Treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Information about family/significant others (past and present): _____

_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression
____ Alcohol dependence
____ Anger
____ Antisocial behavior
____ Anxiety
____ Avoiding people
____ Chest pain
____ Cyber addiction
____ Depression
____ Disorientation
____ Distractibility
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

What are your goals for therapy? _____

_____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

FAMILY INFORMATION

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	_____	_____	____	____	____	____
Father	_____	_____	____	____	____	____
Spouse	_____	_____	____	____	____	____
Children	_____	_____	____	____	____	____
	_____	_____	____	____	____	____
	_____	_____	____	____	____	____

Significant others (e.g., brother, sisters, grandparents, step relatives, half relatives. Please specify relationship.)

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____

Marital Status (more than one answer may apply)

____ Single

____ Legally married
Length of time: _____

____ Widowed
Length of time: _____

____ Divorce in process
Length of time: _____

____ Separated
Length of time: _____

____ Annulment
Length of time: _____

____ Unmarried, living together
Length of time: _____

____ Divorced
Length of time: _____

Total number of marriages: ___

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

Parental Information

____ Parents legally married

____ Parents have been separated

____ Parents divorced

____ Mother remarried: Number of times: _____

____ Father remarried: Number of times: _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? __Yes ___ No

If Yes, please describe: _____

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): _____

_____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? ____ Yes ____ No

If Yes, describe: _____

LEGAL

Current: Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

PAST HISTORY

DWI, DUI, etc.: ____ Yes ____ No
Criminal involvement: ____ Yes ____ No
Civil involvement: ____ Yes ____ No
If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes____ No

____ High school grad/GED
____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training: _____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe): _____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

MEDICAL/PHYSICAL HEALTH

List any significant past health concerns:_____
List any current health concerns: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level
____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: _____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	____	____	____	____
Barbiturates	_____	_____	_____	_____	____	____	____	____
Valium/Librium	_____	_____	_____	_____	____	____	____	____
Cocaine/Crack	_____	_____	_____	_____	____	____	____	____
Heroin /Opiates	_____	_____	_____	_____	____	____	____	____
Marijuana	_____	_____	_____	_____	____	____	____	____
Caffeine	_____	_____	_____	_____	____	____	____	____
Nicotine	_____	_____	_____	_____	____	____	____	____
Over the counter	_____	_____	_____	_____	____	____	____	____
Prescription drugs	_____	_____	_____	_____	____	____	____	____
Other drugs	_____	_____	_____	_____	____	____	____	____

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Describe when and where you typically use substances: _____

Reason(s) for use: ____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe: _____