Tamika Reeves MA, LPC, NCC

Intake Assessment Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session. Use back of pages or attach additional pages if necessary.

Today's Date: _____

GENERAL INFORMATION

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age: _____ Gender [ ] Male [ ] Female

Address:

_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) May we leave a message Yes No

Cell/Other Phone: ( ) May we leave a message Yes No

E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

Race/Ethnicity: _____

Cultural Considerations:

_____

Religion:

_____

Education High School:

_____

(Where) (Last grade completed) (Graduated?)

Post High School Education: Explain:

_____

_____

Is or was school performance a concern for you? If yes, explain:

_____

_____

Marital/Relationship Status:

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Committed Relationship

Years Married: _____ Years Divorced: _____

Are you currently in a romantic relationship? _____

If yes, for how long?

_____

On a scale of 1-10 how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?_____

_____

_____

Children:

Do you have children? If so child/children current_____ age_____

_____

Who currently lives in your household?_____

_____

Describe your relationship with:

Parents:

_____

_____

Siblings:

_____

_____

Extended Family Members:_____

_____

Husband/Wife/Significant Other:_____

_____

_____

Your Children:_____

_____

Health History

Primary Physician:

_____

Primary Physicians Address:

_____

Primary Physicians Phone: _____Date of Last Exam_____

Please List Allergies if
Any_____

Have you previously received any type of mental health services (Psychotherapy (Counseling), Psychiatric services?) Yes_____ No_____ If yes, when and where?

_____

_____

List any support groups/Psychotherapy you have attended in the past or presently:

_____

_____-

Was support group/Psychotherapy attendance helpful? Explain:

_____

_____

Are you currently taking any prescription medications? Yes_____ No_____ Please list:

_____

Have you ever been prescribed psychiatric medication? Yes_____ No_____ Please list:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMAITON

*How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing:_____

_____

_____

_____

*How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

_____

_____

_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

Yes_____ No_____

If yes, approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

If yes, when did you begin to experience this?

_____

_____

Are you currently experiencing any chronic pain?

If yes, please describe: _____

Are any physical characteristics or body image a concern? Explain:

_____

_____

Is sexual functioning an area of concern for you? Explain:

_____

_____

Substance Use

Do you drink alcohol more than once a week? Yes_____ No_____

If yes, how often? _____

Is alcohol an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

How often do you engage in recreational drug use?

Daily____ Weekly____ Monthly _____ Never____

Is recreational drug use an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle ECT.).

Please Circle List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Abuse History

Have you experienced physical, sexual or emotional abuse? Yes___ No___

If yes,
explain_____

_____

Legal History

Do you have a history of any legal charges? Yes_____ No_____

If yes,
explain_____

_____

Are you currently on probation or parole? Yes_____ No_____

If yes,
explain_____

_____

Is treatment court ordered? Yes_____ No_____

Employment Are you currently employed? Yes____ No_____

If yes, what is your current employment situation?

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Additional Information

What do you consider to be some of your strengths?

_____

_____

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

_____

_____

What are effective coping strategies you have learned?

_____

_____
_____
_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____
_____
_____
_____
_____

Is there anything else you feel we should know, or that you are concerned about?

_____
_____
_____
_____

Emergency Contact: Name_____

Relationship to you: _____

Address:

_____

Home_____Cell_____Work_____

Client's or Guardian's Signature_____Date_____

Counselor's Signature &
Credentials_____Date_____