



**Intake Information/Assessment**

**General Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

May we contact you at home?  YES  NO at work?  YES  NO on your cell phone?  YES  NO

E-mail Address \_\_\_\_\_ Can we contact you via e-mail?  YES  NO

Gender  Female  Male Religious Affiliation? \_\_\_\_\_

Ethnicity  African American  American Indian/Alaskan Native  Asian/Pacific Islander  Jewish  
 European American (Caucasian)  Hispanic/Latino  Other \_\_\_\_\_

Referral Source \_\_\_\_\_ Release of Information  YES  NO

Fee Reimbursement  Cash  Credit Card  Insurance (In-Network)  Insurance (Out-of-Network)

Type of consultation you are seeking:

Individual  Couple/Marriage  Family  Group  Other \_\_\_\_\_

**Emergency Contact**

Release of Information  YES  NO

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Family Contact**

Release of Information  YES  NO

Do you want family members/friends involved in your treatment planning and provided with updated progress?  YES  NO

If so, who do you want involved?  parents  siblings  spouse  offspring  other \_\_\_\_\_



**Intake Information/Assessment**

**► Description of Presenting Problem(s)**

State in your own words the nature of what brings you here today—your issues, concerns, and problems:

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Estimate the severity of your issues/problems:

Severity Index \_\_\_\_\_

- none    low    moderate    high    very high    catastrophic

Why—How is it affecting your life? \_\_\_\_\_

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Please check any of the following areas that are currently presenting you stressors:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Self-care             | <input type="checkbox"/> Spouse/Partner       | <input type="checkbox"/> Living Situation   |
| <input type="checkbox"/> Leisure               | <input type="checkbox"/> Children             | <input type="checkbox"/> Education/Training |
| <input type="checkbox"/> Religion/Spirituality | <input type="checkbox"/> Family               | <input type="checkbox"/> Employment         |
| <input type="checkbox"/> Financial             | <input type="checkbox"/> Social Life          | <input type="checkbox"/> Legal Issues       |
| <input type="checkbox"/> Transportation        | <input type="checkbox"/> Mental Health System | <input type="checkbox"/> Substance Abuse    |
| <input type="checkbox"/> Mental Illness        | <input type="checkbox"/> Physical Illness     | <input type="checkbox"/> Eating Disorder    |
| <input type="checkbox"/> Emotional Abuse       | <input type="checkbox"/> Physical Abuse       | <input type="checkbox"/> Sexual Abuse       |

Other \_\_\_\_\_

Duration of issues/problems—When did they begin? \_\_\_\_\_ (date)

Duration Index \_\_\_\_\_

- 2 weeks or less    2 to 4 weeks    1 to 6 months    6 to 12 months    1 to 5 years    more than 5 years

Was there a specific circumstance to cause the issues/problems? \_\_\_\_\_

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How would you rate your coping skills:

Coping Index \_\_\_\_\_

- none    inadequate    somewhat    adequate    above average    outstanding

What makes your life work as well as it does? \_\_\_\_\_

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**Intake Information/Assessment**

► **Safety Assessment**

Means \_\_\_\_\_

Do you currently have suicidal thoughts?  YES  NO

Do you have the intent of following through with your suicidal thoughts?  YES  NO

Do you have a plan?  YES  NO If yes, what is it? \_\_\_\_\_

Do you have thoughts of harming someone else?  YES  NO

Explain \_\_\_\_\_

► **Mental Health Services**

Please list previous mental health services you have received (therapy, groups, day treatment, partial, hospitalizations)?

When/Date	Where/Location	By Whom/Name & Telephone

What did you find helpful? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications	Dose	Why Prescribed?



**Intake Information/Assessment**

What do you believe your diagnosis to be? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatrist \_\_\_\_\_ Telephone \_\_\_\_\_ Release  YES  NO

Address \_\_\_\_\_

Therapist \_\_\_\_\_ Telephone \_\_\_\_\_ Release  YES  NO

Address \_\_\_\_\_

Family Doctor \_\_\_\_\_ Telephone \_\_\_\_\_ Release  YES  NO

Address \_\_\_\_\_

**► Goals**

Please describe your goal(s) for therapy—How would you like to enhance your quality of life?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you expect therapy in your situation to be:

- 1 to 10 sessions     11 to 20 sessions     more than 20 sessions     lifetime/ongoing as needed

On a scale of 1 (low) to 10 (high) I would rate my **energy** level as \_\_\_\_\_

On a scale of 1 (low) to 10 (high) I would rate my **willingness to follow-through** with what I learn from therapy \_\_\_\_\_

On a scale of 1 (low) to 10 (high) I would rate my **self-esteem** as \_\_\_\_\_



**Intake Information/Assessment**

**► Family Psychiatric History**

Have any of your family members (blood relatives) struggled with the following mental health issues? Please check appropriate columns.  Check here if adopted and/or biological family psychiatric history unknown

	Father	Mother	Brothers	Sisters	Aunts/Uncles		Grandparents	
					Paternal	Maternal	Paternal	Maternal
Substance Abuse								
Depression								
Anxiety								
Bipolar Disorder-Manic/Depressive								
Schizophrenia - Psychotic Episode								
Suicide Attempt								
Psychiatric Hospitalization								

**► Current Psychological Symptoms**

Check any of the following that you have been experiencing in the past 3 months:

Depressed/Unhappy	Irritable	Insomnia	Excessive Worries
Low Motivation	Forgetful	Racing Thoughts	Social Anxiety
Difficulty Concentrating	Appetite Change	Impulsive/Risk-Taking	Obsessive Thinking
Socially Withdrawn	Low Self-Esteem	Too Much Energy	Rituals to Lower Anxiety
Excessive Sleeping	Low Sex Drive	Tense/Stressed	Anxiety; Past Trauma
Nightmares	Worthless/Guilty	Restless/Pacing	Feeling “Numb”
Tearful/Crying Spells	Hopelessness	Angry Outbursts	Flashbacks While Awake
Fatigue	Suicidal Thoughts	Legal Trouble	Avoiding People
Confused Thoughts	Loss of Interest/Activities	Panic Attacks	Drinking Excessively
Confused Feelings	Difficulty with Decisions	Feeling Lonely	School Problems
Fears/Phobias	Self-Injurious Behaviors	Family Problems	Relationship Problems
Work Problems	Financial Problems	Coping with Abuse	Gambling Problem

Check any of the following physical sensations that often apply:

Headaches	Dizziness	Vomiting	Hearing Things
Tingling	Heart Racing	Stomach Problems	Visual Disturbances
Muscle Spasms	Blackouts	Neck/Back Pain	Tics/Twitches
Muscle Tension	Flushing	Trouble Swallowing	Odd Sensations
Itchy or Burning Skin	Excessive Sweating	Bowel Problems	Tremors
Dry Mouth	Chest Pain	Chronic Pain	Sensitivity to Touch
Unable to Relax	Fainting spells	Weight Concerns	Sexual Problems

Other \_\_\_\_\_



**Intake Information/Assessment**

**► Substance Abuse History**

Do you consume alcohol?  YES  NO

If yes, how many alcoholic drinks do you have on an average weekday? \_\_\_\_\_ Weekend night? \_\_\_\_\_

Do you have a history of treatment/evaluation for alcohol problems?  YES  NO If so, when? \_\_\_\_\_

Have you ever used street drugs, or illicit substances?  YES  NO

If yes, what have you used? \_\_\_\_\_

When? \_\_\_\_\_

Do you have a history of treatment/evaluation for drug related problems?  YES  NO If so, when? \_\_\_\_\_

Have you been seen for gambling problems?  YES  NO

Do you have other addictive behaviors that you have concerns about?  YES  NO If so, what? \_\_\_\_\_

How often, or how much do you smoke cigarettes?

None, I have never smoked cigarettes.

None now, I did in the past. Age when started: \_\_\_\_\_ Age when stopped \_\_\_\_\_

I am currently a smoker. Age when started: \_\_\_\_\_

Only occasionally  Less than one pack per day  One to two packs per day  More than two packs per day

Have you ever used other tobacco products (cigar, pipe, chewing tobacco)?  YES  NO

If yes, what have you used, when, and how often? \_\_\_\_\_

Average number of caffeinated drinks per day (coffee, soda, etc)  1  2-3  4-6  More than 6

**► Medical History**

How would you describe your current health?  Excellent  Good  Fair  Poor

How would you describe that you care for yourself?  Good  Pretty Good  OK  Not at all

Please list any current and/or chronic medical problems, surgeries, or significant injuries:

\_\_\_\_\_  
\_\_\_\_\_

How many hours of sleep per night do you get? \_\_\_\_\_ What time do you normally go to bed? \_\_\_\_\_ Get Up? \_\_\_\_\_

Do you have any problems with sleep? \_\_\_\_\_



**Intake Information/Assessment**

Have you ever had a concussion, head injury, or lost consciousness?  YES  NO

If yes, please explain: \_\_\_\_\_

Last physical exam? \_\_\_\_\_ Last eye exam? \_\_\_\_\_

Did you have the following labs?  Thyroid – TSH \_\_\_\_\_ (0.30-5.00)  Blood Sugars – A1C \_\_\_\_\_ (4%-6% normal)  
 Iron  B12  Hormone/Testosterone Level  Other \_\_\_\_\_

**► Social/Developmental History**

Where were you born? \_\_\_\_\_ Where did you grow up? \_\_\_\_\_

I have \_\_\_\_\_ brothers and \_\_\_\_\_ sisters. I was born:  1<sup>st</sup>  2<sup>nd</sup>  4<sup>th</sup>  5<sup>th</sup>  6<sup>th</sup>  7<sup>th</sup>  Other \_\_\_\_\_

Relationship with my siblings is/was  close  distant  hostile  neutral  non-existent

Parents are (check all that apply):  never married  still married  separated  divorced  deceased  unknown

If parents divorced, how old were you? \_\_\_\_\_ Who raised you? \_\_\_\_\_

Father: Age \_\_\_\_\_ Occupation \_\_\_\_\_ My childhood relationship with him was \_\_\_\_\_

If deceased, age/date/cause of death \_\_\_\_\_

Mother: Age \_\_\_\_\_ Occupation \_\_\_\_\_ My childhood relationship with her was \_\_\_\_\_

If deceased, age/date/cause of death \_\_\_\_\_

If applicable:

Relationship to step-father is  close  distant  hostile  neutral  non-existent

Relationship to step-mother is  close  distant  hostile  neutral  non-existent

If adopted, have you made a connection with your biological parents?  YES  NO

Overall, my childhood was  Very Happy  Happy  OK  Unhappy  Very Unhappy

Have you ever been abused?  YES  NO If so, what kind?  Emotional/Verbal  Physical  Sexual

If applicable, who abused you? \_\_\_\_\_

Check any areas that applied to you in your childhood and/or adolescent years:

<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Legal Trouble
<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Frequent Fighting
<input type="checkbox"/> Family Problems	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fire Setting
<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Learning Disability/ADHD	<input type="checkbox"/> Stealing
<input type="checkbox"/> Running Away	<input type="checkbox"/> Medical Problems	<input type="checkbox"/> Social Problems
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> School Truancy
<input type="checkbox"/> Stuttering	<input type="checkbox"/> Anger Control Problems	<input type="checkbox"/> School Problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Self-Harm	<input type="checkbox"/> Feeling Alone



**Intake Information/Assessment**

**► Current Life Situation**

- Never Married
- Married, how long? \_\_\_\_\_
- Living with significant other, how long? \_\_\_\_\_
- Separated
- Widowed
- Divorced, but not remarried
- Divorced, and remarried

Spouse/Significant Other's age \_\_\_\_\_ Spouse/Significant Other's occupation \_\_\_\_\_

Have you or your spouse/significant other been married before? If so please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have children, please list names, ages, and living arrangements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Are you having parenting concerns?  YES  NO

Check all that apply with regard to your present marriage/relationship:

- Close and Trusting
- Alcohol/Drug Abuse
- Cold and Hostile
- Poor Communication
- Distant but Loyal
- Controlling
- Problem Trusting Spouse/Significant Other
- Sexual problems
- Physical/Emotional/Sexual Abuse

**► Educational History**

- How far did you go in school?  Less than 12<sup>th</sup> grade  Some Technical Education
- GED, when? \_\_\_\_\_  Completed Technical Training \_\_\_\_\_
- High School Diploma  Some College
- What were your grades?  Associates Degree \_\_\_\_\_
- A  B  C  D  Presently a Student  Bachelors Degree \_\_\_\_\_
- Favorite Subject \_\_\_\_\_ For What \_\_\_\_\_  Some Graduate Training
- Where \_\_\_\_\_  Graduate Degree \_\_\_\_\_



**Intake Information/Assessment**

Ever repeat a grade in school? If so, which one and why?

\_\_\_\_\_  
Were you ever suspended or expelled from school? If yes, please explain why and number of times?  
\_\_\_\_\_

How social were you in school? Did you have many friends?  
\_\_\_\_\_

What extracurricular activities were you involved with during school (i.e., sports, band, clubs, etc.)?  
\_\_\_\_\_

**► Occupational History**

Are you currently employed?      YES    NO

If yes, what do you do? \_\_\_\_\_

Where do you work? \_\_\_\_\_

When did you start working there? \_\_\_\_\_ Do you like your present job?    YES    NO

If you are currently volunteering, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

If you are unable to work or volunteer, how do you structure your day?  
\_\_\_\_\_  
\_\_\_\_\_

**► Exercise and Leisure Time**

What do you do for exercise and how often? \_\_\_\_\_

What limits the amount of exercise that you can do? \_\_\_\_\_

What do you do during your leisure time—for fun and pleasure?  
\_\_\_\_\_

**► Legal History**

Are you currently facing, or do you have a history of legal problems?

Commitment    Stay of Commitment    Probation    Parole    Alcohol/Drug Related

Child Protective Services (CPS)    Divorce    Custody    Unlawful Detainer    Bankruptcy

Other \_\_\_\_\_



## Intake Information/Assessment

### ► Strengths/Weaknesses

What do you consider your weaknesses/vulnerabilities?

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What do you consider your major strengths?

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### ► What Is Working For You

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What is your support network?

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### ► Comments

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Hope Allianz's mission is to inspire and empower you to create an authentic quality of life with wisdom and knowledge while promoting mental, physical, and spiritual health.

Thank you for your time, candor and helpfulness in completing this form. Your therapist, Jody L Friesen Grande PhD LICSW BCD will review it and discuss it with you thoroughly at your intake session. This information is confidential and private. No one will have access to it without your written authorization.

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Signature

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Date