

INTAKE ASSESSMENT INFORMATION – Family and Couple Therapy Services, Inc.

Client Name:	Date:
Therapist:	Best Phone(s):

Immediate Medical Concerns/History – Client Please Fill Out

Medical/Physical Concerns: NO YES (Note Concerns) History:

Abuse of Substance/Medication/History – Client Please Fill Out

Substance/Medication Abuse: NO YES (Note Type of Abuse) History:

Tobacco Marijuana Heroin Cocaine/Crack PCP Alcohol Hallucinogens Rx Other

Frequency Daily 2-3 x Wk. 4-5 x Mo. Recreational Seldom Not Since _____ (year)

Psycho-Social History/Self Report – Client Please Fill Out

Family History (See Genogram) Significant Personal Events: (i.e. Family, Educational, Career, Cultural, Relationships, Faith, etc.)

- 1.
- 2.
- 3.
- 4.
- 5.

Current Mental Status -- Therapist Fills Out

Current Mental Status:	Poor.....Excellent	Comments
1. Affect	1 2 3 4 5 6 7 8 9 10	
2. Mood	1 2 3 4 5 6 7 8 9 10	
3. Thought-Content	1 2 3 4 5 6 7 8 9 10	
4. Insight	1 2 3 4 5 6 7 8 9 10	
5. Judgment	1 2 3 4 5 6 7 8 9 10	
6. Speech	1 2 3 4 5 6 7 8 9 10	
7. Attention	1 2 3 4 5 6 7 8 9 10	
8. Concentration	1 2 3 4 5 6 7 8 9 10	
9. Impulse Control	1 2 3 4 5 6 7 8 9 10	
10. Memory	1 2 3 4 5 6 7 8 9 10	

Ideation for Suicidal or Homicidal Thoughts -- Therapist Fills OutRisk Assessment: Homicidal/Suicidal Thoughts: NO YES (If yes note reasons for thoughts)Need to Report? NO YES**Child – Adolescent – Teen Assessment – Client Please Fill Out**

Child -- Developmental History	Normal (Note)	Abnormal (Note)
Birth to Age 2		
Age 3 to Age 6		
Age 7 to Age 12		
Age 13 to Age 18		

What Brought You To Therapy? (List Presenting Problems) – Client Please Fill Out**Therapeutic Diagnosis and Other Information -- Therapist Fills Out**

DSM:IV (TR) Diagnosis:

Comments

Axis I _____; _____ (Clinical Disorders)

Axis II _____; _____ (Personality Disorder/MR)

Axis III _____ (Medical)

Axis IV Psycho-social & Environmental Problems:

Axis V Global Assessment of Functioning GAF (Current Number) _____

Client Please Fill Out Permission to contact Primary Care Provider (PCP) to inform he or she that you are in counseling. YES NO

(If YES – Fill out Authorization at Office -- If NO -- client sign _____.)

Client Please Fill Out Do we have permission to contact your previous or concurrent Mental Health Practitioner (MHP). YES NO

(If YES – Fill out Authorization at Office -- If NO -- client sign _____.)

Therapist Signature:

Title:

Date: