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: q NO q YES (Note Concerns) History:

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

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

qTobacco q Marijuana q Heroin q Cocaine/Crack q PCP q Alcohol q Hallucinogens q Rx q Other
Frequency q Daily q 2-3 x Wk. q 4-5 x Mo. q Recreational q Seldom q 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 Out
Risk Assessment: Homicidal/Suicidal Thoughts: q NO q YES (If yes note reasons for thoughts)
Need to Report? q NO q 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. q YES q 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). q YES q NO

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

Therapist Signature: Title: Date: