



## *Assessment for Intake*

### Identification:

Age: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Referral (if applicable): \_\_\_\_\_

### History of Present Problem:

Symptoms: \_\_\_\_\_

Onset: \_\_\_\_\_

Duration: \_\_\_\_\_

Frequency: \_\_\_\_\_

### Past Psychiatric History:

Prior Treatment: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Suicide Attempts: \_\_\_\_\_

Suicidal Ideation Behavior: \_\_\_\_\_

Violent History: \_\_\_\_\_

Trauma History:

Nature of Trauma: \_\_\_\_\_

When Occurred: \_\_\_\_\_

Persons Involved: \_\_\_\_\_

Other Information: \_\_\_\_\_

Family Psychiatric History:

History of Mental Illness in Family: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

Medical Conditions & History:

Past Medical Conditions: \_\_\_\_\_

Treatments: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications:

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Purpose: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Substance Use:

Substance: \_\_\_\_\_

Start Date: \_\_\_\_\_

Last Use: \_\_\_\_\_

Amount: \_\_\_\_\_

Frequency: \_\_\_\_\_

Family History:

Family of Origin: \_\_\_\_\_

Relationship with Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Significant Others: \_\_\_\_\_

Social History:

Significant Relationships: \_\_\_\_\_

Social Support: \_\_\_\_\_

Nature/Quality of relationships: \_\_\_\_\_

Developmental History:

Developmental Milestones: \_\_\_\_\_

Delays: \_\_\_\_\_

Educational/Occupational History:

Highest Level of Education: \_\_\_\_\_

Current Employment: \_\_\_\_\_

Legal History:

Arrest History: \_\_\_\_\_

Sentencing: \_\_\_\_\_

Incarcerations: \_\_\_\_\_

Strengths: \_\_\_\_\_

\_\_\_\_\_

Limitations: \_\_\_\_\_

\_\_\_\_\_

Anything else you would like us to know about you: \_\_\_\_\_

\_\_\_\_\_