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New Client Intake Assessment and Medication Evaluation Form

Date_____

Full name_____

Address_____

Cell#_____Work#_____Home#_____

Restrictions for calling/leaving messages?_____

Emergency contact: Name & #_____Relationship_____

Gender_____ Race_____ Age & Birthdate_____

Sexual orientation? Heterosexual / Homosexual / Bisexual / Transgender / Asexual

Questioning / Decline to answer / Other _____

Drivers license #_____ Social security #_____

Who can I thank for referring you to me?_____

Briefly describe the specifics of the problem(s) with which you would like help:_____

_____

_____

Employment History

Hours worked per week: Over-time (over 40 hrs) / Full-time (35+ hrs)

Part-time (17-34 hrs) / Irregular (< 17 hrs) / Unemployed

Occupation_____ Employer_____

Length of employment_____ Are you satisfied with your job?_____

Do you currently / or in the past, have problems maintaining employment?_____

If yes, is this due to outside forces (i.e. economy) or difficulties with relationships with peers / supervisors / customers?_____

Circle if applies: Late for work / Absenteeism / Quit / Fired / Diminished productivity

Educational History

Enrolled in school now?____ Full or part time?_____ Highest grade completed?_____

How well did you do in school? Excellent / Good / Fair / Poor

How were your relationships with your teachers? Excellent / Good / Fair / Poor

How were your relationships with your peers? Excellent / Good / Fair / Poor

Mark any of the following experiences that were relevant to you while going to school:

___ Afraid to go to school

___ Bullied / teased by others

___ You bullied / teased others

___ Diagnosed with a learning disability

___ Suspended / expelled

___ Failed / repeated a grade(s)

___ Skipped classes frequently

___ Refused to go to school

___ Had an IEP ___ Moved frequently
___ Attended special classes / alternative school

Developmental History

Mark and/or circle the following experiences that were relevant to you while growing up:

____ Loving / supportive home environment
____ Inconsistent / Unstable home environment
____ Chaotic home environment
____ Witnessed physical / verbal / emotional / sexual abuse / or neglect toward others
____ Experienced physical / verbal / emotional / sexual abuse / or neglect from others
____ Was physically /verbally /emotionally /sexually abusive /or neglectful toward others
____ Depressed as a child / teen
____ Anxious as a child / teen
____ ADD/ADHD as child / teen
____ Wet the bed after age 7
____ Ran away from home
____ Lived in home other than parents
____ Teen pregnancy
____ Frequently lied to family & others
____ Was cruel to animals
____ Set fires

Other problems_____

Family History

Relationship status: Committed relationship / Single / Married / Separated / Divorced
Partner deceased / No previous relationship / Other_____
If you're in a relationship, how many months / years have you been together?_____
Do you feel safe in this relationship?_____
Describe your level of satisfaction with the relationship_____
_____
Are you or have you ever been in a violent / abusive intimate relationship?_____
_____
Living arrangements: Alone / Spouse / Partner / Parent(s) / Relative(s) / Friend(s)
Child(ren) / Roommate(s) / Other_____
Mother's name & age_____
Alive?____ General health state_____
Mental health state_____
Describe your relationship: Excellent / Good / Fair / Complicated / Bad / Nonexistent
Did your mother abuse alcohol or drugs?_____
Were you: neglected / verbally / emotionally / physically / sexually abused by her?_____
What ages did it start & stop?_____
Did either of *her* parents or siblings have mental health or substance abuse issues?___
_____

Father's name & age_____

Alive? ____ General health state_____

Mental health state_____

Describe your relationship: Excellent / Good / Fair / Complicated / Bad / Nonexistent

Did your father abuse alcohol or drugs?_____

Were you: neglected / verbally / emotionally / physically / sexually abused by him?____

What ages did it start & stop?_____

Did either of *his* parents or siblings have mental health or substance abuse issues?____

_____

Are your parents divorced?_____ Your age at the time?_____

Any step parents?_____ If yes, describe your relationship:_____

_____

Do you have siblings? Yes / No

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

Did any of your siblings (or step siblings): verbally / emotionally / physically / sexually abuse you?_____

What ages did it start & stop?_____

Do you have children? Yes / No

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

_____

Name, sex, age Mental health state

Social and Spiritual Support System

Many / Several / Few / No Supportive friends Substance-use based friends?____

Many / Several / Few / No Supportive family members

Currently participating in spiritual / religious activities?_____

Currently participating in community activities?_____

Military History

Military service?_____ Branch?_____ Active / Reserve / Veteran / Retired

Did you serve in combat?_____Honorable discharge?_____

Did you experience disciplinary actions against you while serving?_____

_____

Legal History

Have you ever been arrested or involved in any court proceedings?_____

_____

Have you ever spent time in jail or prison?_____

Other legal problems_____

Alcohol, Drugs, and Addiction History

Mark any of the following drugs that you have taken, indicating present or past use.

None ____

Tobacco - Present ____ Past ____ Packs per day____

Marijuana - Present ____ Past ____

Prescription opiates (oxycodone / oxycontin / other) - Present ____ Past ____

Street opiates (cocaine / crack / heroin / other) - Present ____ Past ____

Street amphetamines (meth / other) - Present ____ Past____

Prescribed stimulants (ritalin / adderall / dexedrine / other) - Present ____ Past ____

Prescribed / Street benzodiazepines (xanax / ativan / other) - Present ____ Past ____

Hallucinogens (LSD / mushrooms / mescaline / PCP / other) - Present ____ Past ____

MDMA (ecstasy) - Present ____ Past ____

Inhalants (type:_____) - Present ____ Past ____

Other_____

How many alcoholic beverages do you consume in an average day?_____ week?_____

What is your beverage(s) of choice?_____

What is your typical serving size for one beverage (how many shot's, oz's, pint's, etc)?

_____

At what time of day do you have your first drink?_____
Has anyone ever told you or do you feel like you should cut down on your drinking?___
Have you ever felt guilty or bad about your drinking?_____
Have you ever drank in the morning to steady your nerves/get over a hangover?_____
Have you ever received a DUI?_____Do you drink & drive?_____
Have you been treated for alcohol or drug abuse in the past?_____
_____
How much time per day / per week do you spend: on the internet (not work)?_____
viewing TV?_____ gambling? _____ non-essential shopping?_____
viewing pornography?_____ other addiction?_____

Medical History

Describe your current state of health: Excellent / Good / Fair / Poor
Do you exercise?____ Type?_____Days per week?____ Hours per day?____
Mark all that applies to describe your usual diet, specifically carbohydrates:
____ Simple (*white* breads, rice, pasta, processed and high sugar foods)
____ Complex (*brown* breads, rice, pasta, whole grains/minimally processed, low sugar)
____ Sugar-free products (nutrasweet /splenda /saccharine /stevia) other_____
How many meals do you eat per day? _____ How many snacks per day? _____
How many glasses/oz of water per day?_____
How many cups/glasses per day of caffeinated coffee?_____ tea?_____ pop?_____
Indicate if there is any history of the following conditions in yourself or your family:
Alcoholism / Drug addiction - Self____ Family ____
Anemia / blood disorder - Self ____ Family ____
Cancer - Self ____ Family ____
Chronic pain - Self____ Family ____
Diabetes - Self ____ Family ____
Epilepsy - Self ____ Family ____
Gastrointestinal issues - Self ____ Family ____
Heart problems - Self ____ Family ____
High blood pressure - Self ____ Family ____
Kidney disease - Self ____ Family ____
Liver disease - Self ____ Family ____
Lung disease - Self ____ Family____
Muscular/Skeletal - Self ____ Family ____
Smoking - Self ____ Family ____
Stroke - Self ____ Family ____
Thyroid issues - Self ____ Family ____
Other:_____
Last time your thyroid level was checked?_____ Was it normal? _____
Last time your Vitamin D level was checked?_____ Was it normal?_____
Current health concerns?_____
Have you *ever* had a head injury?_____

For women: Regular periods / Irregular periods / Heavy periods / Long periods
Pre-menstrual Syndrome / Peri-menopausal / Menopause _____

_____

List all past surgeries, or serious injuries:_____

_____

_____

Name & phone # of your primary care provider?_____

_____

Sleep History

How many hours of sleep do you get per night during the week (or work days)?_____
How many hours of sleep do you get per night on weekends (or days off)?_____
How many hours of sleep do you need to feel your best?_____Does it vary?_____
Do you sleep well?_____Are you sleepy during the day?_____Do you take naps?____
Do you go to bed and get up at the same time each day?_____
Do you have trouble falling asleep?_____ How long does it take?_____
Do you have problems waking up at night?_____ How often?_____
How long does it take you to get back to sleep?_____
Do you ever go all night without sleeping because you can't get to sleep?_____
Does pain keep you from falling asleep or wake you up?_____
Does your mind race, keeping you from falling asleep?_____
Do you worry or are you anxious while trying to fall asleep?_____
Do you consume caffeinated products within 6 hours of going to bed?_____
Do you use tobacco products within 6 hours of going to bed?_____
How much alcohol do you drink before bed?_____
Do you eat within 3 hours of going to bed?_____ Do you wake up to eat?_____
Has anyone told you that you hold your breath or stop breathing while sleeping?_____
Do you experience a creeping/crawling sensation, restlessness or jerking in your legs while trying to fall asleep?_____

Circle if applies: Talk in your sleep / Grind teeth / Nightmares / Wake up in panic

Quiet room / TV or radio on / White noise / Dark room / Lights on / You snore

Partner snores / You toss & turn / Partner tosses & turns / Sleep walk / Other ____

Mental Health History

Have you ever been a patient in an outpatient mental health treatment program?_____
Have you ever been hospitalized for a mental health crisis?_____
Have you ever been diagnosed with a mental health disorder?_____

_____

Have you ever thought about suicide?_____ Was it in the past? ____ or currently?____
Have you ever made a plan?_____An attempt?_____

Current Symptoms

Mark *only* the symptoms that you are experiencing using the following scale:

1 = Mild difficulty **2** = Moderate difficulty **3** = Severe difficulty

____ Sad most of the time
____ Hopeless
____ Tearful
____ Helplessness
____ Feelings of guilt
____ Lost interest in friends & activities
____ Social isolation
____ Low motivation
____ Lacks confidence
____ Worthlessness
____ Grief / loss
____ Mood swings
____ Fatigue / low energy
____ Irritability
____ Poor concentration
____ Easily distractible
____ Can't turn my mind off
____ Difficulty comprehending things
____ Difficulties with memory
____ Mood changes with weather
____ Poor appetite / weight loss
____ Increased appetite / weight gain
____ Bingeing
____ Self induced vomiting (bulimia)
____ Dangerous calorie restriction (anorexia)
____ Grandiose (over the top) notions
____ Taking unnecessary risks
____ Inappropriate social behavior
____ Self destructive
____ Anger outbursts
____ Startles easily
____ Can't stop remembering past events
____ Self mutilation (i.e. cutting)

____ Preoccupation with death
____ Excessive worry
____ Fearful
____ Anxious
____ Tension
____ Chest pain
____ Panic attacks
____ Phobias
____ Tics/involuntary movements
____ Repetitive thoughts
____ Repetitive behaviors
____ Sexual difficulties
____ Decreased sex drive
____ Increased sex drive
____ Paranoia
____ Overly energetic
____ Impulsive
____ Poor judgment
____ Excessive elation
____ Unable to keep friends
____ Secretive
____ Aggressive
____ Lying
____ Argumentative
____ Blames others
____ Abusive to others
____ Destructive to property
____ Hears things others do not
____ Sees things others do not
____ Access to weapons
____ Suicidal thoughts
____ Homicidal thoughts

How long have you been experiencing these symptoms?_____

Medication Evaluation

List **ALL** current and past medications that you've taken for your mental health_____

_____

_____

_____

Did you take the medication consistently?_____

Did you respond well to the medication (was it helpful)?_____

_____

List ***ALL*** prescription medications, over the counter medications, homeopathic / herbal treatments, amino acids, vitamins, & minerals that you're *currently* taking, & what condition or symptoms you're taking them for: _____

_____

_____

_____

For women: Is it possible that you're pregnant?_____ Trying to get pregnant?_____

List **ALL** allergies to any medications, foods, or other substances and describe your reaction:_____

_____

_____

Names and #'s of **ALL** pharmacies where you fill your prescriptions_____

_____

Are you currently in therapy?_____ Have you had therapy in the past?_____

How long ago & duration of therapy?_____

Was it helpful?_____

Current therapist's name and #_____

If not in therapy, I strongly recommend using therapy concurrently with medication to achieve the best results. Would you like some referrals for therapist's?_____

Karmen's Notes:_____

_____

_____

_____

_____

_____

_____

_____