Symptom/problem description cont.	*Currently a problem (x)*	*How long has it been a problem?/comments*	*Therapist Comments*
Difficulty being alone	☐		
Difficulty in relationships	☐		
Self-injury behavior	☐		
Risky or reckless behavior	☐		
Feelings of unreality / being detached from self	☐		
Repetitive behaviors (such as hand-washing, ordering, counting, or checking)	☐		
Recurring dreams	☐		
Flashbacks after an event	☐		
Distinct periods of inflated self-esteem, excessive spending, goal-directed activity, or racing thoughts	☐		
Persistent difficulty with fidgeting, feeling on the go, interrupting others, talking too much, or having impatience	☐		
Persistent difficulty with forgetfulness, sustaining attention, or completing tasks	☐		
Less effective at home, school, or work	☐		

Trauma History

Have you experienced any of the following?

Emotional abuse ☐ Yes ☐ No Sexual abuse ☐ Yes ☐ No Physical abuse ☐ Yes ☐ No

If yes, please explain:

____

____

____

____

Have you ever witnessed verbal aggression or physical fighting? ☐ Yes ☐ No

If yes, please explain:

____

____

Have you ever experienced trauma not explained above**?** ☐ Yes ☐ No

If yes, please explain:

____

____

____

Support System

Who do you rely on most when you need help? ____

Any recent changes in support system? ____

Alcohol / Other Drug Use

Please check all that apply.

		Comments	***Therapist Comments***
Do you drink alcohol?	☐ Yes ☐ No		
Have you ever had treatment for alcohol or drug use?	☐ Yes ☐ No		
Do you use drugs? If yes, please indicate which drug(s), amount, and how often.	☐ Yes ☐ No		
Have you ever thought you drink or use drugs too much?	☐ Yes ☐ No		
Has anyone ever expressed concern about your drinking or drug use? If yes, indicate who and why.	☐ Yes ☐ No		
Have you ever felt remorseful or embarrassed about your usage?	☐ Yes ☐ No		
Has drinking or drug use created unhappiness in your home, relationships, or marriage?	☐ Yes ☐ No		
Have you had any legal difficulties or traffic incidents as a result of your drinking or drug use?	☐ Yes ☐ No		
Has work, school, or other interests/activities been affected by your drinking or drug use?	☐ Yes ☐ No		
Do you use drugs or alcohol to relax, reduce tension, or escape from problems?	☐ Yes ☐ No		
Have you had health problems that were related to your alcohol or drug use?	☐ Yes ☐ No		
Have you ever experienced any black outs?	☐ Yes ☐ No		
Have you ever had difficulty controlling or limiting your drinking or drug use?	☐ Yes ☐ No		
Have you ever felt distracted or had obsessive thoughts of drinking or using drugs?	☐ Yes ☐ No		

Medical History

Do you have or have you ever had any of the following:		***Any comments?***	***Therapist comments***
Allergies	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No		
High or low blood pressure	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No		

Do you have or have you ever had any of the following:		***Any comments?***	***Therapist comments***
Diabetes	☐ Yes ☐ No		

Digestive problems	☐ Yes ☐ No		
Headaches	☐ Yes ☐ No		
Head injury	☐ Yes ☐ No		
Hearing problems	☐ Yes ☐ No		
Heart disease	☐ Yes ☐ No		
Incontinence / bed wetting	☐ Yes ☐ No		
Kidney problems	☐ Yes ☐ No		
Liver disease (e.g. hepatitis)	☐ Yes ☐ No		
Neurological problems (e.g. seizures)	☐ Yes ☐ No		
Sexual problems	☐ Yes ☐ No		
Thyroid problems	☐ Yes ☐ No		
Vision problems	☐ Yes ☐ No		
Miscarriage / abortion	☐ Yes ☐ No		
Currently pregnant	☐ Yes ☐ No ☐ Maybe		

Please list any other medical concerns or conditions: ______________________________

____

____

Please list any medications you are currently taking. Also, please state what they are used for.
(Please include herbal, over-the-counter, & prescribed items)

Prescription name (or herbal name):	***For:***	***Prescribed by:***

Have you taken any psychiatric medications in the past? ☐ Yes ☐ No If yes, please list:

____

If yes, were they effective? ______________________________

<u>Primary Care</u> - Physician Information

Physician's name: ______________________________

Name of practice: ______________________________ Phone #: ______________

How would you rate your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Not very good ☐ Poor

How often do you worry about your health?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Always

Mental Health History

Have you received counseling before? ☐ Yes ☐ No

If yes, when, where, and with whom?

____

What type of counseling services did you receive? ____________________

Have you been to Family Service before? ☐ Yes ☐ No

If yes, when, with whom, & what services were provided? ____________________

Are you interested in receiving information about other services & programs that Family Service can provide? ☐ Yes ☐ No

Treatment Goals

What changes would you like to see as a result of the services you receive? Beginning with the most important goal, please indicate three goals.

1. ____

2. ____

3. ____

Please describe the specific changes in your life that will be signs that things are improving:

____

What are some barriers that have interfered with change so far, including any personal weaknesses or other limitations?

____

Please describe your personal strengths, assets, and accomplishments, including those you have used to help you overcome previous difficulties.

____

Please Stop When You Get Here ☺

Completed by Family Service Staff
Intake Assessment

Presenting Problem/ Symptoms:

Client Strengths and Supports
Recent Changes to Support System:

Mental Status Evaluation

Appearance	☐ appropriate	☐ well-groomed	☐ inappropriate	☐ disheveled	☐bizarre	
Orientation	☐ fully-oriented	☐ not fully-oriented (describe:)		☐ normal	☐ impaired	
Speech	☐ relevant ☐ loud	☐ normal ☐ precise	☐ logical ☐ soft	☐ slow	☐ incoherent ☐ rapid/pressured	
Affect	☐ appropriate	☐ inappropriate	☐ flat	☐ constricted	☐ agitated	☐ tearful
Thought Process	☐ intact ☐ blocked	☐ abstract ☐ concrete	☐ loose associations ☐ circumstantial	☐ vague ☐ flight of ideas	☐ tangential	
Thought Content	☐ normal ☐ confusion	☐ paranoia ☐ delusions	☐ obsessions ☐ hallucinations	☐ other:		
Intelligence	☐ above average	☐ average	☐ below average			
Mood	☐ appropriate ☐ angry	☐ sad ☐ irritated	☐ anxious ☐ euphoric	☐ panicky ☐ despairing	☐ depressed ☐ bored	
Motor Activity	☐ normal ☐ aggressive	☐ overactive ☐ compulsive	☐ under-active ☐ seductive	☐ other:		
Attitude	☐ cooperative	☐ uncooperative	☐ guarded	☐ suspicious	☐ belligerent	
Reliability	☐ appears to be truthful	☐ appears to minimize	☐ appears to exaggerate			
Insight	☐ above average	☐ average	☐ limited	☐ absent	☐ unable to assess	
Judgment	☐ good	☐ poor	☐ unable to assess			
Harm to Others Thought/Intent	☐ absent	☐ present	If present, safety plan			
Suicide Risk: Thought/Intent	☐ absent	☐ present	If present, complete suicide safety plan			

AODA Information - Note: AODA treatment requires AODA specialty or a referral to an AODA specialist

Primary AODA treatment needed: ☐ Yes ☐ No

☐ Client referred elsewhere for AODA Name:

☐ Client referred to internal expert: Name:

Purpose of internal or external referral:

Other Referrals ____

____

Diagnostic Criteria (DSM-5):

Principal Diagnosis		
Other		
Other		

Important psycho-social or contextual factors:

Disability or medical considerations:

Case Conceptualization: ____

____

____

____

____

____

____

Consultant / Supervisor recommendations (trainees/supervisory protocol): ____

____

____

____

THERAPIST'S ATTESTATION: *"My signature below indicates that I have completed a mental health assessment sufficient to determine the client's need for outpatient treatment and I have reviewed and discussed with the client all information collected and contained herein".*

______________________________ ______________________________

Therapist Signature **Date**

______________________________ ______________________________

Signature of Supervisor (trainees/supervisory protocol) **Date**

Date of initial staffing: ______________________________ **Date VOCA completed**:____________________