Genuine Therapy Center, LLC
Real Conversations. . . Real People

INTAKE ASSESSMENT

Revised 4-23-15

INTAKE DATE: _____ INTAKE THERAPIST: _____

HOW YOU HEARD ABOUT Genuine Therapy Center, LLC _____

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CLIENT INFORMATION:

CLIENT NAME: _____ SEX: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE #: (____) _____ Message ok? ☐ Yes ☐ No

_____ WORK #: (____) _____ Message at work? ☐ Yes ☐ No

Cell #: (_____) _____ Message on Cell? ☐ Yes ☐ No

EMAIL _____ Text Reminder ☐ ok ☐ not ok

Age: _____ GRADE: _____ SCHOOL/Employer: _____

PARENT(S) / GUARDIAN (S): _____

Partner/Spouse: _____

SOCIO ECONOMIC STATUS, CULTURE, RELIGION, ETHNIC BACKGROUND:

Ethnicity	**Economic Status**	**Religion**	**Marital status**	**Sexual Orientation**
☐ White-non Hispanic	☐ lower class	☐ Christian	☐ Married	☐ Heterosexual
☐ Hispanic	☐ Middle Class	☐ Judaism	☐ Divorced	☐ Gay
☐ African American	☐ Upper Middle Class	☐ Islam	☐ Separated	☐ Lesbian
☐ Asian American	☐ Upper Class	☐ Buddhism	☐ Single	☐ Bisexual
☐ European American	☐ other	☐ New Age	☐ Widowed	☐ Trans
☐ Pacific islander	☐	☐	☐ Other	☐ other
☐ Native American	☐	☐		☐

MILITARY HISTORY ☐ No ☐ Yes ☐ Still Active ☐ Discharged

Type of Discharge: ☐ Honorable ☐ Dishonorable ☐ Medical ☐ Unknown

Combat Experience ☐ No ☐ Yes ***Explain:***

PRESENTING CONCERNS:

(Briefly describe what problem(s) have led you to enter into counseling at this time)

SIGNIFICANT SX:
(Please list the SX which are causing you stress and describe their history and development)

Symptom	Yes	No	Please Describe:
Anxiety			
Nervousness/ worry more days than not in the past 6 months	☐	☐	
Feel restless or fidgety	☐	☐	
Get tired easily	☐	☐	
Difficulty concentrating	☐	☐	
Tension in your muscles	☐	☐	
Having problems sleeping or staying asleep	☐	☐	
Panic	☐	☐	
Separation/ school/ social	☐	☐	
Specific phobias	☐	☐	
Obsessions/ compulsions	☐	☐	
Trauma	☐	☐	
Flashbacks	☐	☐	
Nightmares	☐	☐	
Triggered by visual stimuli	☐	☐	
Reoccurring memories	☐	☐	
Physical reaction to triggers/cues	☐	☐	
Avoiding distressing memories	☐	☐	
Unable to remem. periods of time	☐	☐	
Feeling detached	☐	☐	
Hyper vigilance	☐	☐	
Somatic complaints	☐	☐	
Encopresis/ enuresis	☐	☐	
Lose Stools	☐	☐	
Feeling anxious/worried for < 6mos	☐	☐	
Feeling anxious/worried for > 2yrs	☐	☐	
Mood			
Sadness	☐	☐	
Tearfulness	☐	☐	
Irritability	☐	☐	
Decrease/ Increase pleasure	☐	☐	
Decrease/increase of weight w/o dieting	☐	☐	
Decrease/ Increase sexual interest	☐	☐	
Decreased/Increase need for Sleep	☐	☐	
Decrease/Increase in Energy level	☐	☐	
Decrease/Increase in Appetite	☐	☐	
Hopelessness	☐	☐	
Helplessness	☐	☐	
Guilt	☐	☐	
Suicidal Ideation	☐	☐	
Problems concentrating	☐	☐	
Flight of ideas/ loose associations	☐	☐	
Rapid/ uninterruptible speech	☐	☐	
Unprotected sex, shopping sprees, foolish bus. invest, sharing needles.	☐	☐	
Mood swings	☐	☐	

Feeling low for < 6mos	☐	☐	
Feeling Low for > 2 years	☐	☐	
Attention	☐	☐	
Difficulty paying attention	☐	☐	
Trouble finishing what s/he starts	☐	☐	
Forgetful	☐	☐	
Struggles to pay close attention to detail	☐	☐	
Do not listen when spoken to	☐	☐	
Often loses things	☐	☐	
Easily Distracted	☐	☐	
Told to sit still/ trouble sitting still	☐	☐	
Often Fidgets	☐	☐	
Trouble for running/ climbing/loud	☐	☐	
Unable to take part in leisure activities	☐	☐	
Often "on the go"	☐	☐	
Difficulties waiting turn	☐	☐	
Trouble for talking too much	☐	☐	
Interrupting	☐	☐	
Barging into others games/ push into groups	☐	☐	
Conduct			
Loses temper often/throws tantrums	☐	☐	
Talks back/ argues	☐	☐	
Breaks rules	☐	☐	
Refuses to obey adults	☐	☐	
Blames others	☐	☐	
Gang activity	☐	☐	
Cheat/ lies/ "cons"	☐	☐	
Stolen from car/ building/ person	☐	☐	
Skips school/ stays out late	☐	☐	
Bullying/ starting fights/ fighting	☐	☐	
Used a weapon	☐	☐	
Hurt someone for no reason	☐	☐	
Damaged property	☐	☐	
Set fires	☐	☐	
Hurt or killed animal for fun	☐	☐	
Played with others sexual parts/ forced sex	☐	☐	
Running away	☐	☐	
Thought			
Hears voices	☐	☐	
Sees things	☐	☐	
Lack of Pleasure in everyday Life	☐	☐	
Disorganized Thinking	☐	☐	
Repetitive Movements	☐	☐	
Feels someone is out to harm him/ her	☐	☐	
Feels people are talking behind his/ her back	☐	☐	
Acted in a bizarre way for no reason	☐	☐	
Lost ability to speak or walk	☐	☐	

Thought Blocking(feeling like a thought has been taken our your head)	☐	☐	
Eating	**Yes**	**No**	
Refusal to maintain body weight	☐	☐	
Intense fear of gaining weight	☐	☐	
Disturbance in the way in which weight or shape is experienced	☐	☐	
Loss of at least 3 menstrual cycles (not due to pregnancy)	☐	☐	
Recurrent episodes of binge eating or a sense of a lack of control over eating	☐	☐	
Recurrent behavior such as: vomiting, misuse of laxatives, diuretics, enemas, or medications	☐	☐	
Bing and purge at least 2x/ week for at least 3 mos.	☐	☐	
Self-image is unduly influenced by shape and weight	☐	☐	
Self-injurious activities			
Picking	☐	☐	
Plucking (Hair, eye brows, eye lashes)	☐	☐	
Cutting	☐	☐	
Burning	☐	☐	
Branding	☐	☐	
Punching/Hitting self or objects	☐	☐	
Tattooing	☐	☐	

RISK ASSESSMENT

Family history of suicide/homicide	Personal history of suicide/homicide	Current Risk
☐ Assessed, no risk	☐ Assessed, no risk	☐ No Risk
☐ Suicidal thoughts	☐ Suicidal thoughts	☐ Current thoughts
☐ Homicidal/assaultive thoughts	☐ Homicidal/assaultive thoughts	☐ Current plan
☐ Suicidal gesture/attempt	☐ Suicidal gesture/attempt	☐ Current threat to self
☐ Homicidal/assaultive gesture/attempt	☐ Homicidal/assaultive gesture/attempt	☐ Current threat to others
☐ Completed suicide	☐ Completed suicide	☐ Willing to contract for safety
☐ Completed homicide/assault	☐ Completed homicide/assault	

LOSSES:

☐ Death	☐ Autonomy
☐ Employment	☐ Other:

☐ Finances	

Summary of Risk Assessment & Losses:

PREVIOUS PSYCHIATRIC TX:

(List any psychiatric services you have received)

☐ **Yes** ☐ No

Date	Psychiatrist Name/ Clinic	Issues addressed	Helpful
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

PREVIOUS HOSPITALIZATIONS:

(List any Psychiatric Hospitalizations: date, locations, reason for hospitalization)

☐ Yes ☐ No

Date	Hospital Name	Issues addressed	Helpful
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

PREVIOUS THERAPY:

(list any and all counselors you have seen previously and include clinic names and dates)

☐ **Yes** ☐ No

Date	Therapist/Clinic	Issues addressed	Helpful
			☐ Yes ☐ No
			☐ Yes ☐ No

			☐ Yes ☐ No

PHYSICAL / MEDICAL HISTORY: (please list any significant physical or medical problems, any hospitalizations, etc)

Primary Care Clinic: _____ Consent to communicate w/ PCP: ☐ Yes ☐ No

Primary Care Physician: _____. Phone: _____

Address: _____Fax:_____

Date of Last Medical Appointment _____.

Concerns addressed: _____.

Are you currently pregnant? ☐ Male ☐ Yes ☐ No Due Date: _____

Receiving prenatal care ☐ Yes ☐ No

Allergies: ☐ None ☐ Food ☐ Environment ☐ Animal ☐ Medical ☐ Seasonal

Explain: _____

What are the SX: _____.

Medical conditions: _____

Do you take medication(s)? ☐ Yes ☐ No

Please list all medications including vitamins and over the counter drugs

Medication	Dosage	Frequency	Taking As Prescribed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

DEVELOPMENTAL HISTORY:

Normal full-term birth: ☐ Yes ☐ No *Explain:* Click here to enter text.

Normal developmental milestones:

Age at which you: walked (normal?): ☐ Yes ☐ No *Explain:*.

Age at which you: talked (normal?): ☐ Yes ☐ No *Explain:*

Age at which you: toilet trained (normal?): ☐ Yes ☐ No *Explain:*.

SUMMARY OF BIOMEDICAL HISTORY:

HISTORY OF PHYSICAL OR EMOTIONAL TRAUMA:

Physical Abuse: ☐ Yes ☐ No *Explain:* _____.

Emotional Abuse: ☐ Yes ☐ No *Explain:* _____

SEXUALITY:

Unwanted Sexual Experience: ☐ Yes ☐ No *Explain:* _____.

Age of First Wanted Sexual Experience: _____

Sexually Active: ☐ Yes ☐ No *Explain:* _____

Abuse HX Summary:

EDUCATIONAL HISTORY:

Class Type	Services	Area (s) of LD	Behavior Problems I	Behavior Problems II
☐ Mainstream	☐ LD	☐ Reading	☐ Aggression	☐ W/drawal
☐ Spec Ed	☐ E/BD	☐ Math	☐ Work refusal	☐ Truancy
☐ Day TX	☐ Dev. Delays	☐ Written Language	☐ Poor social skills	☐ Suspensions
☐ Advanced Placement	☐ IEP/504 Plan	☐ Speech		

School(s) Attended: _____

Highest Grade completed: _____☐ GED

Post-Secondary: ☐ None ☐ Trade School ☐ 2 yr. college ☐ 4 yr. College ☐ Graduate

OCCUPATIONAL HISTORY:

(Please describe your past and current occupational experiences)

Employed ☐ Yes ☐ No Full Time: ☐ Part Time: ☐ On call ☐

Who is your employer? _____. Hire Date: _____

History of employment: _____

Occupational Concerns: _____

FAMILY HISTORY: (please describe your immediate family:-1.who you live with, 2.their names and ages, 3.yours or other children, 4.how they get along)

EXTENDED FAMILY HISTORY: (please describe your family of origin (mother, father, siblings); Include: 1. names/ages, 2. relation to you, 3. any history of drug, physical or other abuse, 4. describe your current relationship)

CHEMICAL USE HISTORY: (please describe any alcohol usage, past & present, drug usage, past & present, and any treatment programs you or your family members may have attended if appropriate)

□ NONE □ Yes

What is your Drug (s) of Choice (DOC)?
☐ Alcohol ☐ Nicotine ☐ Marijuana ☐ Cocaine ☐ Hallucinogens ☐ PCP ☐ Amphetamines ☐ Opiates ☐ Inhalants

☐ Sedative/Hypnotics/Anxiolytics ☐ Pornography ☐ Gambling ☐ Other: _____

Describe your drug and alcohol use pattern:

Describe your drug and alcohol use pattern for the last six months:

SUMMARY OF SUBSTANCE USE:

LEGAL FACTORS: (list any and all factors of a legal nature that may have an effect on your life at this point or has affected in the past)

Have you ever been incarcerated? ☐ Yes ☐ No How much time have you served incarcerated?
Are you currently on probation? ☐ Yes ☐ No Probation Officers name: _____
Phone Number_____ County: _____

Conditions of Probation:

□ No Alcohol	□ No Drug use	□ No possession of a weapon/firearm
□ Attend TX	□ CD assessment	□ Participate in Mental Health assessment
□ Community Service	□ No same or similar	□ Participate in MH Therapy
□ Random UA's	□ Do not leave the state	□ Other: _____

Child Protection involvement: (has child protection ever opened a case or done an investigation)

☐ None ☐ Yes Explain: _____

Conditions of CPS:

☐ No Alcohol	☐ No Drug use	☐ parenting education
☐ Attend TX	☐ CD assessment	☐ Anger Management
☐ Community Service	☐ No same or similar	
☐ Random UA's	☐ Other: _____	

ADDITIONAL DATA: (please use this space to add any data that you feel would be important for your therapist to know

**********DIAGNOSTIC SUMMARY AND TREATMENT PLAN**************

MENTAL STATUS

Appearance	☐- Well Groomed	☐- Disheveled	☐- Inappropriate	☐- Poor Eye Contact	☐- Poor Hygiene
Attitude	☐- Cooperative	☐- Distracted	☐- Withdrawn	☐- Demanding	☐- Guarded
Mood	☐- Comfortable	☐- Depressed	☐- Anxious	☐- Euphoric	☐- Irritable
Affect	☐- Appropriate	☐- Flat	☐- Labile	☐- Sad/tearful	☐- Apathetic
Speech	☐- Normal	☐-Slurred	☐- Soft/reduced	☐- Excessive/Loud	☐- Pressured
Thought	☐- Intact	☐-Circumstantial	☐- Disorganized	☐- Blocking	☐- Loose Association
Perception	☐- No Problem	☐-Delusions	☐- Paranoia	☐- Hallucinations	☐- Preoccupations
Motor	☐- Calm	☐- Agitated	☐- Hyperactive	☐- Tremors/tics	☐- Slowed
Cognitive	☐- Oriented x3	☐- Poor memory	☐- Poor Attention	☐- Poor Concentration.	☐- Judgment. Impaired
Intelligence	☐- Mental Retard.	☐-Below Ave.	☐- Average	☐- Above Ave.	☐- Undetermined
Insight	☐- Age appropriate	☐- Denial	☐- Slight Insight	☐- Blames self	☐- Blames others

DSM V Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: GAF _____

SERVICE(S) RECOMMENDED:

Mental Health Services	Chemical health services	Activity Recommendation
☐ Individual counseling	☐ Detoxification	☐ No Alcohol or Drug Use
☐ Family counseling	☐ Residential/Inpatient	☐ AA/NA 12 step support group
☐ Group counseling	☐ IOP w/ Lodging	☐ Sponsor/Coach
☐ Cognitive skills group	☐ IOP 3-6 days a week (group therapy)	☐ Random U/A's
☐ Anger Management Group	☐ OP 2-3 days a week	☐ MADD Panel
☐ Couple counseling	☐ Cognitive Skills Group 2 days/wk	☐ DWC – Level 1 program (12 hours)
☐ EMDR	☐ No Alcohol or Drug Use	☐ DWC – Level II Program (24 hours)
☐ DBT	☐ RX – Alcohol MAT	☐ DWC – Level III Program (36 Hours)
☐ TF-CBT	☐ RX – Opioid MAT	☐ Routine exercise
☐ Bio-Feedback	☐ No Recommendations in this column	☐ Join a Support group
☐ RX – for Mental health	☐	☐ Reclaim faith
☐ Individual Skills Training	☐	☐ Seek a faith
☐ Family Skills Training		☐ Learn a new hobby
☐ Day Treatment		☐ No Recommendations in this column
☐ Partial hospitalization		☐
☐ Hospitalization		☐
☐ Residential Treatment		
☐ No Recommendations in this column		

ASSESSMENT SUMMARY AND RECOMMENDATIONS:

THERAPY GOALS:

Goal	Interventions	Date of completion

CLIENT SIGNATURE: _____ DATE:_____

PARENT SIGNATURE (IF MINOR) _____ DATE:_____

THERAPIST/ASSESSOR NAME: _____DATE: _____

THERAPIST SIGNATURE: _____ DATE:_____