




INTAKE WORKSHEET

Name: _____

 = questions for patients under 16 only

Is this a Potential court case?

Re-admission: Have you been a patient of ours before?

Source: Patient Parent Other: _____

Have you had Previous Counseling?: (Where, when, what for?) _____

Referral Source & Reason For Referral

How did you hear about us (be very specific)?: _____

Why did you come here instead of somewhere else?: _____


Reason For Referral (if from another professional): _____

Pg 2 - Presenting Problem / Symptoms of Problem, History of Problem & Triggers

Pg 3 - Present Family Problems & Strengths
Marital/Sexual History

Pg 4 - Family of Origin
Culture

Pg 5 - Educational/Vocational (Interpersonal, Personal, Military)

Pg 6 -  Educational History
Leisure Activities / Daily Functioning

Pg 7 - Legal Status

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Pg 11 - Substance Abuse
Religion/Spirituality

Pg 12 - Client Statements

 CAR Scores

Diagnostic Summary

PRESENTING PROBLEM

In a sentence or two, why are you coming to counseling?:

Problem 1: " _____ "

Problem 2: " _____ "

Problem 3: " _____ "

SYMPTOMS OF PROBLEM

How did you notice the problem? How have others noticed it? How has the problem affected your daily life?: (Indicate Frequency / Duration / Severity)

Problem 1:

a) _____ (F/D/S)

b) _____ (F/D/S)

c) _____ (F/D/S)

Problem 2:

a) _____ (F/D/S)

b) _____ (F/D/S)

c) _____ (F/D/S)

Problem 3:

a) _____ (F/D/S)

b) _____ (F/D/S)

c) _____ (F/D/S)

-COMPLETE "DSM-5 SELF-RATED CROSS-CUTTING SYMPTOM MEASURE-

In the past, how have you dealt with these problems, what has been most helpful?:

Problem 1: _____

Problem 2: _____

Problem 3: _____

HISTORY OF THE PROBLEM: (How long has this been going on? How did it start?):

_____ (use back of this sheet as needed)


RECENT TRIGGER OF PROBLEM: (Why get help for it NOW? What's happened recently?):

What recent incidents or problems that may have triggered and/or been associated with this problem.

_____ (use back of this sheet as needed)

BIOPSYCHOSOCIAL HISTORY

MARITAL AND FAMILY INFORMATION

 Living with: Biological Parents Mom/Step-dad(BF) Dad/Step-mom(GF) Grandparents Other

PRESENT FAMILY PROBLEMS / CONCERNS / STRESSORS

(What are the issues of conflict in the family?):

STRENGTHS/RESOURCES IN THE FAMILY/FRIENDS (What are the best things about your family?):

Among your friends and family, whom do you count on for support - who is "there for you"? _____

MARITAL/SEXUAL HISTORY PATTERNS :

Marital Status: Living together Divorced Married Separated Single (Never married) Widowed

Intimate Relationship: Never been in an IR Not currently in relationship Currently in IR

How long have you been in the current relationship? _____

How many times have you been married/long-term relationship? _____

1. _____ 3. _____

2. _____ 4. _____

Relationship Satisfaction: Very satisfied Satisfied Somewhat satisfied Dissatisfied Very dissatisfied

Describe your relationship with your current partner (Issues of Conflict, Strength of Support):

FAMILY OF ORIGIN

(Problems in Family of Origin, Family Background, Ethnic Factors)

What was it like growing up in your family? _____

What significant childhood family experiences do you recall? _____

Any childhood traumas? _____

Would you describe your Social Development as "normal" - i.e. relationships in school, dating, friendships, etc.? _____

Have you ever been a victim / witnessed Domestic Violence? Yes No
--other than a Family member? Yes No

Have you ever been a victim / witnessed Sexual Assault/Abuse? Yes No
--other than a Family member? Yes No

While growing up, did you live under the care of anyone other than your parents? Yes No

Who administers(ed) discipline in the family of origin? _____
How was punishment given? _____

Cultural

Ethnic Origin: Caucasian African American Hispanic Asian
 Native American Eskimo Mixed Unknown Other: _____

Tribal Affiliation (name of tribe) _____ (CDIB Card ?)

Primary language: _____ Secondary language: _____

Does the family:
SPEAK English well? Yes No / READ English well? Yes No / WRITE English well? Yes No

If no, please describe: _____

EDUCATIONAL/VOCATION

Employed Dependant Public Assistance Workers' Compensation Illegal Unemployment

Employment status and history: _____

INTERPERSONAL CONCERNS/PROBLEMS:

How many close friends do you have? _____

How do you get along with others? Where do you fit in a group?

PERSONAL STRENGTHS at Work/School:

What are the best things about you at Work/School? What would others say they like about you at Work/School?

MILITARY/WORK PROBLEMS:

Military history: _____

List work stressors: _____

 EDUCATIONAL HISTORY

Current Educational Functioning

How many schools have you attended? _____

What grade are you currently attending? _____

Did you repeat any grades? _____ Why? _____

What subjects do you like in school? _____

What subjects do you dislike in school? _____

Would you describe yourself as a: quick learner; average learner; slow learner

Have you ever taken an I.Q. test? Yes No If yes, what was your score? _____

Current school status? Currently Attending Drop-out Expelled Truant

Graduated/GED Homebound/Medical Suspended

What is your current school performance (grades or GPA)? _____

Do you have a special education classification?

Lab LD ED/SED MR Other Health Impairment

Are you currently being served on an IEP? Yes No

How long have you been receiving special education classes? _____

In what grade did you start receiving special education classes? _____

LEISURE ACTIVITIES/DAILY FUNCTIONING

Special interests or hobbies? Yes No

If yes, please describe: _____

What do you do or have you done for fun or enjoyment? _____

- Decreased interest in leisure activities
- Too much time spent in leisure activities
- Gave up leisure activities
- Impaired functioning
- No change in leisure activities / time spent

Notes: _____

LEGAL STATUS

Has there been any legal action for any person in the immediate family in the last 5 years?

Any arrests in the past six months? _____

Explain: _____

Is anyone in the family on probation or parole? Yes No

Divorce pending: _____

DUI's: _____

Arrests: _____

Charge(s): _____

of Convictions: _____

Probation until: _____

Paroled On: _____

Protective service involvement: _____

Work related lawsuit: _____

Medical malpractice: _____

Other legal problem (specify): _____

No legal problems

Case Worker/Parole Officer Name: _____	Phone: _____
Address: _____	City: _____ County: _____ State: _____ Zip: _____

Notes: _____

MEDICAL

Describe current physical health: _____

No medical problems

Anorexia Bulimia Obesity Special diet

How many times has client been hospitalized overnight for medical problems: _____


Describe reasons for all overnight hospitalizations: _____
 _____ (use additional page if needed)

Current biomedical conditions/complications: _____

Handicaps/Disabilities/Limitations/Challenges

Are you now or have you ever experienced any chronic medical, ambulatory, speech, hearing or visual functioning problems? _____

Medication Allergies / Food Allergies / Reactions: _____

 Are your immunizations current? Yes No

If no, what are you lacking? _____]

CURRENT MEDICATIONS

<i>Physician</i>	<i>Medication</i>	<i>Type (Check)</i>	<i>Dosage/Strength</i>	<i>Frequency</i>	<i>Start Date</i>	<i>Side Effects</i>	<i>Benefits</i>
_____ First Name - Last Name	_____ <input type="checkbox"/> Current?	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter					
_____ First Name - Last Name	_____ <input type="checkbox"/> Current?	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter					
_____ First Name - Last Name	_____ <input type="checkbox"/> Current?	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter					
_____ First Name - Last Name	_____ <input type="checkbox"/> Current?	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter					
_____ First Name - Last Name	_____ <input type="checkbox"/> Current?	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter					
_____ First Name - Last Name	_____ <input type="checkbox"/> Current?	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter					
_____ First Name - Last Name	_____ <input type="checkbox"/> Current?	<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter					

Developmental

 **For Children/Adolescents:**

Were developmental age factors, motor development and functioning, prenatal/perinatal events accomplished within appropriate time frames? Yes No Unknown

First word: ____ (months) First step: ____ (months)

Problems during mother's pregnancy: <input type="checkbox"/> difficult delivery <input type="checkbox"/> none <input type="checkbox"/> high blood pressure <input type="checkbox"/> kidney infection <input type="checkbox"/> German measles <input type="checkbox"/> emotional stress <input type="checkbox"/> bleeding <input type="checkbox"/> alcohol use <input type="checkbox"/> drug use <input type="checkbox"/> cigarette use <input type="checkbox"/> other: _____	Birth: <input type="checkbox"/> normal delivery <input type="checkbox"/> German measles (age ____) <input type="checkbox"/> cesarean delivery <input type="checkbox"/> complications _____ Birth weight _____ lbs ____ oz. Infancy: <input type="checkbox"/> feeding problems <input type="checkbox"/> sleep problems <input type="checkbox"/> toilet training problems	Childhood health: <input type="checkbox"/> chickenpox (age _____) <input type="checkbox"/> mumps (age _____) <input type="checkbox"/> red measles (age _____) <input type="checkbox"/> rheumatic fever (age _____) <input type="checkbox"/> whooping cough (age _____) <input type="checkbox"/> scarlet fever (age _____) <input type="checkbox"/> autism <input type="checkbox"/> ear infections <input type="checkbox"/> allergies to _____ <input type="checkbox"/> significant injuries _____ <input type="checkbox"/> chronic, serious health problems _____ <input type="checkbox"/> lead poisoning (age _____) <input type="checkbox"/> diphtheria (age _____) <input type="checkbox"/> poliomyelitis (age _____) <input type="checkbox"/> pneumonia (age _____) <input type="checkbox"/> tuberculosis (age _____) <input type="checkbox"/> mental retardation <input type="checkbox"/> asthma
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Delayed developmental milestones (check only those milestones that did not occur at expected age):

- | | |
|--|--|
| <input type="checkbox"/> sitting | <input type="checkbox"/> controlling bowels |
| <input type="checkbox"/> rolling over | <input type="checkbox"/> sleeping alone |
| <input type="checkbox"/> standing | <input type="checkbox"/> dressing self |
| <input type="checkbox"/> walking | <input type="checkbox"/> engaging peers |
| <input type="checkbox"/> feeding self | <input type="checkbox"/> tolerating separation |
| <input type="checkbox"/> speaking words | <input type="checkbox"/> playing cooperatively |
| <input type="checkbox"/> speaking sentences | <input type="checkbox"/> riding tricycle |
| <input type="checkbox"/> controlling bladder | <input type="checkbox"/> riding bicycle |
| <input type="checkbox"/> other _____ | |

Emotional / behavior problems (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> drug use | <input type="checkbox"/> repeats words of others | <input type="checkbox"/> distrustful |
| <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> not trustworthy | <input type="checkbox"/> extreme worrier |
| <input type="checkbox"/> chronic lying | <input type="checkbox"/> hostile/angry mood | <input type="checkbox"/> self-injurious acts |
| <input type="checkbox"/> stealing | <input type="checkbox"/> indecisive | <input type="checkbox"/> impulsive |
| <input type="checkbox"/> violent temper | <input type="checkbox"/> immature | <input type="checkbox"/> easily distracted |
| <input type="checkbox"/> fire-setting | <input type="checkbox"/> bizarre behavior | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> hyperactive | <input type="checkbox"/> self-injurious threats | <input type="checkbox"/> often sad |
| <input type="checkbox"/> animal cruelty | <input type="checkbox"/> frequently tearful | <input type="checkbox"/> breaks things |
| <input type="checkbox"/> assaults others | <input type="checkbox"/> frequently daydreams | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> disobedient | <input type="checkbox"/> lack of attachment | |

Social interaction (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> normal social interaction | <input type="checkbox"/> inappropriate sex play |
| <input type="checkbox"/> isolates self | <input type="checkbox"/> dominates others |
| <input type="checkbox"/> very shy | <input type="checkbox"/> associates with acting-out peers |
| <input type="checkbox"/> alienates self | <input type="checkbox"/> other _____ |

Intellectual / academic functioning (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> normal intelligence | <input type="checkbox"/> authority conflicts | <input type="checkbox"/> mild retardation |
| <input type="checkbox"/> high intelligence | <input type="checkbox"/> attention problems | <input type="checkbox"/> moderate retardation |
| <input type="checkbox"/> learning problems | <input type="checkbox"/> underachieving | <input type="checkbox"/> severe retardation |

Describe any other developmental problems or issues: _____

Note Psychological, Physical, Social, Intellectual, and Academic Testing: _____

Psychiatric/Mental Health History

How many times have you been treated for any psychological or emotional problems:

In a hospital or inpatient setting? ____

Outpatient/private patient setting? ____

Location/Provider: _____ Date: ___/___/___ Length of time: _____

Diagnosis/Reason: _____

Therapeutic Intervention & Response: _____

Location/Provider: _____ Date: ___/___/___ Length of time: _____

Diagnosis/Reason: _____

Therapeutic Intervention & Response: _____

Location/Provider: _____ Date: ___/___/___ Length of time: _____

Diagnosis/Reason: _____

Therapeutic Intervention & Response: _____

Psychological Tests or Evaluations:

Location/Provider: _____ Date: _____ Test Administered: _____

Reason: _____

Results: _____

Location/Provider: _____ Date: _____ Test Administered: _____

Reason: _____

Results: _____

Have you ever attempted suicide? Yes No

If yes, when? _____ (*Complete Risk/Rescue Rating*)

Is there a family history of suicide? Yes No

Are there firearms in the home? Yes No

Attach reports, discharge summaries, and/or testing.

SUBSTANCE ABUSE

Anyone in your immediate or extended family have problems with drugs or alcohol?

Have you ever been hospitalized or admitted to an inpatient/outpatient facility for drugs or alcohol?

Have you ever received other treatment for drug/alcohol abuse? - outcome (include AA, Narconon, etc):

How much alcohol do you consume weekly? _____

Reason: Socialize __ Manage Stress __ To Relax __ To Change mood __ To Sleep __

<u>Drug of Choice</u>	<u>Amount Used</u>	<u>Frequency of Use</u>	<u>Age First Used</u>	<u>Date Last used</u>
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Functional impact of current use, give examples of level of dependency _____

Increased tolerance over time:

Relationship problems related to use:

Work problems related to use:

Family history of:

Further screening indicated?:

Drinks to intoxication # times per month:

Referral indicated:

Cravings/ withdrawal symptoms:

RELIGION/SPIRITUALITY

I Believe in God I Believe in a higher power Non-believer Unsure Other: _____

It will have an Impact on my therapy It will have No impact

What meaning does God, Spirituality, or a Higher Power play in your life? (In Client's Words):

Does family attend church or religious services? Yes No Where?: _____

Which religion? Protestant Catholic Jewish Islamic Mormon/LDS

Native American Buddhist Hindu Atheist Agnostic Other: _____

Have you had any exceptionally good or bad experiences with the church? Yes No

If yes, please describe: _____

Client Statements (For Treatment Plan)

My abilities/strengths:

Strengths are positive things in a person's life (good social skills, academic strengths, parental support, relationships, etc). Abilities are talents, things the client does well. May include, hobbies, sports, activities, organizations, clubs, academics, groups, jobs, chores, etc. _____

My treatment preferences: _____

My statement of Needs/Weaknesses: _____

What do you hope to get from counseling/therapy? _____

How long do you think it will take? _____

CAR Scores (For SoonerCare Only)

Feeling/Mood _____	Thinking _____	Substance Use _____
Medical/Physical _____	Family _____	Interpersonal _____
Role Performance _____	Socio-Legal _____	Self Care/Basic Needs _____

Diagnostic SUMMARY

The summary must draw on all areas in the earlier parts of the report. New information cannot be introduced.

Essentially the summary will contain a brief outline of:

- Who the patient is
- What their problems are
- What effects the problems are having on the patient

As well as a brief indication of:

- Why the problems arose (precipitating factors)
- How the problems arose (predisposing factors)
- Factors influencing progression/ the course of the problems (perpetuating and protective factors)

(Complete in Therapy Charts)