Brazoria County Counseling Center
120 E. Plum Angleton, Texas 77515
979 549 0889

Adult - Intake Evaluation Form

Client's Name:_____ **Date**_____
D.O.B.:_____

Chief Complaint:

__ Very Unhappy __ Impulsive __ Irritable __ Stubborn __ Stealing __ Temper Outbursts __ Lying
__ Withdrawn __Sexual Issues __ Fearful __ Destructive __ Trouble with the law __ Self Mutilating
__ Eating Problems __ Short Attention Span __ Sleeping Problems __ Distractible __ Sickly
__Lacks Initiative __ Shy __ Tobacco Use __Undependable __Strange Behavior __ Alcohol Use
__ Strange Thoughts __ Crying/Depression __ Phobia __ Suicidal Talk
__ Dependency on Prescribed, Over The Counter Drugs __ Other Drug Dependency

Other/Explain:_____
_____
How long has this been an issue?_____
_____
Problems perceived to be __ Very serious __ Serious __ Not Serious
What was the reason for seeking help at this time?_____
_____
What changes would like to be seen at this time? _____
_____

Psychosocial History

Religious Affiliation that may affect therapy _____
Occupation:_____ Education: _____ Birthplace_____
Birthdate:_____ Age:_____

Marital Status:

__ Married _____ how long Age at time of marriage: (Client) __ (Spouse) ____
__ Separated __ divorced (how long: _____ Deceased: how long ago:_____

Living Arrangements:

How many times has adult moved?____ Places and length of time there? _____
_____
Presently living: __ renting__ buying__ house __ apartment __ other

THERAPIST'S NOTES ONLY:

_____
_____
_____
_____

Client's Name:_____

Children:

Name	Age	Sex	(Full, Half, Step)
1.)			
2.)			
3.)			
4.)			
Deceased sibling: Sex, Name, Age of Death, Circumstances of death:			

Family History of Drug/Alcohol Abuse, Mental Health i.e Depression, Suicide, etc.

_____

_____

Significant Health Issue of a Family Member? If so, Explain:_____

_____

Medical History:

Client Health Information: (all health problems in the past and present)

Illness/Surgeries/Hospitalizations/Serious Accident	What Age
1.)	
2.)	

Name of Primary Care Doctor: _____

Name of Specialist Seen (if applicable) _____

Name of medication	Dose	Reason	Age Prescribed	Amt. of time on Medication
1.)				
2.)				
3.)				

Educational History

Highest level of Education: _____

Legal History

Has client had any difficulty with the police? If yes, explain_____

_____

Client's Name:_____

Has client ever been on probation? If yes, explain_____
_____
Special Interests, Hobbies, Skills:_____

Military History:
Is Client Active Military __ Yes __No Combat History: __ Yes __ No
Branch_____ Discharge Date: _____Type of Discharge_____
Date Enlisted _____Rank at Discharge_____

FOR THERAPIST: DO NOT FILL IN PAST THIS LINE
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Mental Status: (Check all that apply)
Orientation:__ Time _ Person __ Place __ **Appearance:** __ Neat __ Unkempt __ Bizarre
Mood: __ Relaxed __ Anxious __ Fearful __ Suspicious __ Depressed __ Ashamed
__ Guilty ___ Irritable __ Angry __ Happy/Euphoric
Affect: ___ Appropriate/igh __ Inappropriate __ Blunted __ Flat __ Constricted
Thought Process :__Coherent __ Confused __Obsessive__Tangential __ Flight of Ideas
__ Illogical __ Delusional __ Disorganized __ Hallucinating
Estimated Intelligence: __ High __ Average __ Borderline __ Low M/R
Insight : __Good __Limited __ Poor __ None **Judgment** __ Good __ Fair __ Poor

Risk Assessment:
Suicidal __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____
_____
Self Injurious __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____
_____
Homicidal __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____
Assaultive __Current__ Ideation __ Plan __ Attempt(s) __None Currently
Explain _____

Source of Data:Client Self Report _____ Other (Specify)_____

Diagnosis
Axis I:_____

Therapist's Signature and Credentials_____
Date_____ **Start Time: _____ End Time: _____**