Intake and Initial Assessment
Fortitude Therapy and Wellness, PLLC
Lavonne Bryan, MA, LMHC

CLIENT INFORMATION

Legal Name: ____ Date of Birth ______________________

Preferred Name: _____________________________________ Age: _____________________________

Pronouns:____

Gender Identity: Female Male Nonbinary Trans ___________________________________

Racial/Ethnic Identity: Asian Black Latinx Native American White

____

Sexual Orientation: Bisexual Gay Hetero Lesbian Pansexual Queer _______________________

CONTACT INFORMATION

Address: ____ Apt# ______________________________

City: _____________________________State: ____________ Zip Code: _________________________

Mailing Address or P.O. Box: ____

City: _____________________________State: ____________ Zip Code: _________________________

Phone: (HOME) __________________________ OK to leave message? YES NO

Phone:(CELL) _____________________________ OK to leave message? YES NO

E-mail: _________________________________ OK to leave message? YES NO

EMERGENCY CONTACT

Name: ____

Relationship: ___________________________ Phone: ____

Do you give Fortitude Therapy and Wellness permission to contact this individual in the case of an emergency? YES or NO

If yes, please sign here ____
(Signature)

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EDUCATION/EMPLOYMENT

Highest Level of School Completed: 9 10 11 12 GED AA BA/BS MA/MS JD/PhD

Occupation: ________________________________ In School? YES NO ________________________

Employer: __________________________________ Hours worked per week ____________________

Salary: _____________________________________

Guardian's Name (if under 13): ____

RELATIONAL

Relationship status: Single Married Partnered Separated Divorced Widowed

Non-Monogamous Polyamorous

If married/partnered, how long? ____________ If separated/divorced, how long? ___________

Do you have any children? YES NO If yes, do you have custody? _________________

If yes, please note ages and names ____

Who do you currently reside with? ____

MEDICAL INFORMATION

Are you currently receiving medical treatment? YES NO

If Yes, please specify: ____

Current Medications and what taking for: ____

____

Prescriber's Name: ___________________________ Phone: __________________________________

Name of prior Therapist/Clinic (within 3 years): ____

PRESENTING ISSUES

Why are you seeking therapy?

____

____

____

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What are your concerns or goals for therapy?

____

____

How long have you experienced these concerns?

____

Please check any of the following areas related to current or past experience:

____ Addictions	____Aging	____ Auditory or visual hallucinations
____ Anger	____ Anxiety	____Bullying
____ Childhood Abuse	____Chronic Pain	____ Coming out issues
____ Cultural Identity	____ Depression	____ Difficulty focusing
____ Dissociating	____ Domestic Abuse	____ Drug/Alcohol Abuse
____ Eating Disorders	____ Family issues	____Fears/Phobias
____ Financial issues	____Gender care	____ Grief/Loss
____ Health problems	____ Insomnia	____ Legal Matters
____ Nightmares	____ Obsessive thoughts	____ Parenting issues
____ Past/current trauma	____ Postpartum Depression	____ Racial/Ethnic oppression
____ Relationships	____ Religion/Spirituality	____ Self harm
____ Separation/Divorce	____ Sexual Assault	____ Sexual identity
____ Social Anxiety	____Stress	____ Suicidal thoughts
____ Work problems	____ Negative thought patterns	

Other: ____

____

Have you been previously diagnosed with a mental health/psychiatric condition? YES NO

If Yes, please list: ____

Are you currently having suicidal thoughts? YES NO

Have you experienced suicidal thoughts in the past? YES NO

Have you ever attempted suicide? YES NO

If Yes, when and how: ____

____

Have you had any previous psychiatric hospitalizations? YES NO

If Yes, when and where: ____

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family, immediate or extended; been diagnosed or suffer from any mental health issues or substance related disorders? (If yes, please indicate the diagnosis and the family member).

____

____

SUPPORT SYSTEM

Do you have personal supports? YES NO

If Yes, who: ____

REFERRAL SOURCE

How were you referred? Online Directory Website Friend/Family Insurance Other

Name of person/directory/other: ____

MORE INFORMATION:

____

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