**Intake Information Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender:\_\_\_Age:\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Attending:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Concerns:**

* Workplace issues
* Family issues
* Personal issues
* Relational/relationship issues
* Mental Health Symptoms
* Legal issues
* Substance abuse
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has another mental health provider performed any services? Yes No

(Please list other providers here)

Has there been a previous placement at a residential, inpatient or other community setting?

Yes No If yes, please attach any summary information you may have.

**Mental Health Information:**

* Psychiatrist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Agency Involvement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Past Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical Information:**

Known Medical Conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Medications other than Psychotropic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical Conditions/Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Medical Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Abuse/Neglect Information:**

* History of Physical Abuse
* History of Emotional Abuse
* History of Sexual Abuse
* History of Neglect
* History of Sexual Offending/Sexual Acting out
* History of witnessing violence/domestic violence
* Please Explain any of the above:

**Drug/Alcohol Information:**

* Currently using tobacco
* Currently using alcohol
* Currently using marijuana
* Currently using other drugs
* Past usage
* Past Treatment/Recovery
* Further Clarification

**Legal/Juvenile Justice Information:**

* Law Violations in the Community
* Pending
* Diversion
* Probation
* Other

**Workplace:**

* Employed
* Self-employed
* Unemployed
* Other

**Personal/Family:**

* Single
* Married/Partnership
* Children:

**Hobbies/Interests:**

**Symptom/Problem Checklist**

Please place a check mark to indicate whether or not a listed problem or system is an issue in your particular situation. Then circle a ranking of its severity. Feel free to list additional problems and symptoms that are not listed on this checklist.

Scale: 1=Mildly Problematic

2=Problematic

3=Very Problematic

* Suicidal thoughts 1 2 3
* Homicidal thoughts 1 2 3
* Past Attempts at Suicide 1 2 3
* Plans of suicide 1 2 3
* Thoughts of dying/death 1 2 3
* Anger issues 1 2 3
* Sadness 1 2 3
* Irritability 1 2 3
* Sleeping too much 1 2 3
* Sleeping too little 1 2 3
* Appetite Problems 1 2 3
* Low energy 1 2 3
* Problems with focus 1 2 3
* Difficult with organization 1 2 3
* Panic/anxiety attacks 1 2 3
* Feeling Nervous all the time 1 2 3
* Arguing/verbal fighting 1 2 3
* Crying/bouts of crying 1 2 3
* Sensitivity to light/noise/touch 1 2 3
* Difficulty holding still 1 2 3
* Feelings of shame 1 2 3
* Feeling worthless 1 2 3
* Feeling helpless 1 2 3
* Feeling hopeless 1 2 3
* Loss of sex drive/libido 1 2 3
* Sexual acting out 1 2 3
* Confusion about sexual issues 1 2 3
* Constantly thinking about sex 1 2 3
* Drinking alcohol 1 2 3
* Drug use 1 2 3
* Stealing/shoplifting 1 2 3
* Self-harm 1 2 3
* School/Work Difficulty 1 2 3
* Assaultive behaviors 1 2 3
* Hearing voices/seeing things 1 2 3
* Nightmares 1 2 3

**Desired Outcome**

Briefly describe what you would like to happen as a result of treatment.

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**Previous Strategies Attempted**

Please describe any things you have tried before to make things better

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