

Client Intake Assessment

Name: _____

Referral Date: _____

Referred By: _____

Entrance Date: _____

D.O.B.: _____

Ethnicity: White [] (Hispanic [] or Latino []), Asian [], African American [], Native American or Alaskan Native []

I.D. # _____ State issued: _____

Insurance Type _____

Insurance Policy# _____

P.C.P. Name: _____ # _____

Birthplace: _____

Social Security Number: _____

Marital Status: _____

Do you have dependent children? Y/N

Religion/Spiritual Beliefs: _____

Statement of Problem & History: _____

Family & Emergency Contacts:

Next of Kin: _____

Relationship: _____

Address: _____

Telephone: _____

Family/Friend: _____

Relationship: _____

Address: _____

Telephone: _____

Family/Friend: _____

Relationship: _____

Address: _____

Telephone: _____

Emergency Contact: _____

Do you give permission to notify in case of emergency? Yes [] No []

If yes, who would you like contacted? _____

Treatment History:

Did you come from a treatment facility? Yes [] No []

If so which one? _____
What was your discharge date: _____
What is your prior treatment history?

Are you currently receiving treatment? Yes [] No [] If so with whom?

What was your most successful treatment attempt?

12 Step Group History:

Legal History:

Do you have any open cases and/or warrants? Yes [] No []

If so where client was arrested or believes he is wanted by
authorities _____

Where client believes, he is wanted by authorities for arrest and/or
questioning _____

Are you on Probation/Parole? Yes [] No []

Which _____

Probation/Parole Officer Name: _____

Probation/Parole Officer# _____

Sentence, Date Imposed, Offense, Expiration

Date: _____

Condition of
Probation/Parole: _____

Prior Convictions

Misdemeanors

(Offense/Date/Disposition) _____

Felonies

(Offense/Date/Disposition) _____

Any violent crimes? Yes [] No [] If so what?

Any Sex crimes? Yes [] No []

Any Arson? Yes [] No []

Have you been involved in any gangs? Yes [] No [] If yes explain:

Substance Use and Mental Health History:

Primary Drug: _____

Duration of Use: _____

Amount of Use: _____

Frequency of Use: _____

Route: _____

Secondary

Drugs: _____

Drug Type: _____

Duration of Use: _____

Amount of Use: _____

Frequency of Use: _____

Route: _____

Drug Type: _____

Duration of Use: _____

Amount of Use: _____

Frequency of Use: _____

Route: _____

Drug Type: _____
Duration of Use: _____
Amount of Use: _____
Frequency of Use: _____
Route: _____

Are you an IV Drug User? Yes No

Alcohol/Drug Problem:

- | | | |
|--|--|--|
| <input type="checkbox"/> Social Problems | <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Health Problems |
| <input type="checkbox"/> Marriage Problems | <input type="checkbox"/> Family Problems | <input type="checkbox"/> Unable to Stop |
| <input type="checkbox"/> Employment Problems | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> History of Relapse | <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Money Problems |

Have you been diagnosed with a Mental Health Disorder? Yes No

If so what is your diagnosis?

Do you take any medication for your Mental Health Disorder? Yes No

If so what medications?

Family History of Mental Illness:

Mental Health Professional Seen: _____

History of Physical or Sexual Abuse:

Hallucination: Auditory Visual None Other: _____

Delusion: Paranoid Persecutory None Other: _____

Ideation:

Homicidal None

Suicidal None

Means: _____
Plan: _____
History: _____

Intake Participation Level: Active Minimal None
Objective Behavior: Appropriate Hyper vigilant Hostile
 Hypoactive Distracted Hyperactive Suspicious Argumentative Other

Intake Participation Quality:
 Appropriate Resistant Intrusive
 Monopolizing Drowsy

Affect: Appropriate Blunted Labile Sad Flat
Mood: Angry Suspicious Euphoric Ashamed Depressed Anxious
 Fearful Euthymia

Medical History:

Do you have a history of Seizures? Yes No
If so what type of seizure and when was your last one?

Do you have any Medical conditions?

Are you currently prescribed any medications?

Do you have any special preferences that you would like taken into consideration?
Yes No

If so what preferences?

Referrals:

Summary:

Diagnosis:

Printed Client Name

Date

Printed Staff Name

Date

Signed Client Name

Date

Signed Staff Name

Date

