

Intake Assessment

Name: _____ Date: _____

Briefly state the reason you are seeking treatment: _____

Have you ever seen a therapist before? (Circle one): Yes No

If yes, please state to the best of your memory when this was, who the therapist was and the reason for treatment: _____

Do you have any current health concerns: Yes No

If so, what are they? _____

Please list any medications you are currently on: _____

What is your relationship status?: _____

What are your religious or spiritual beliefs, if any? _____

Please circle any of the following that you have a family history of:

Depression	Anxiety	Bipolar Disorder
Substance Abuse	Domestic Violence	Suicide Attempts
Schizophrenia		

Please circle any of the following that you have a personal history of:

Depression	Anxiety	Bipolar Disorder
Substance Abuse	Domestic Violence	Suicidal Thoughts
Suicide Attempts	Schizophrenia	Self-harm

Please circle any of the following forms of abuse that you have experienced:

Verbal/Emotional

Physical

Sexual

What do you consider your strengths to be? _____

What areas do you need to work on? _____

What are your goals for therapy? _____

Is there any other information you feel that I need to be aware of?
