EMBRACE New Life
Elizabeth Davis, MA, LPC-S CHRISTIAN COUNSELING

Adult Intake Assessment

OFFICE USE ONLY - **Intake Classification:**	*OFFICE USE ONLY* - **Baseline:**
Referrer In:	**HAM-A:**
Referral Out:	**HAM-D:**
	SAD PERSONS Scale:
	Hard copies in chart.

CLIENT DATA

Today's Date: _____

Social Security Number: _____ - _____ - _____

***Date of Birth:** _____/_____/_____ Age: _____
Month / day / year

***Name:** _____
Last *First* *Middle/Former Name* *Suffix*

***Hispanic/ Latino:**
- ☐ **No**, not Hispanic/Latino
- ☐ **Yes**, Hispanic/Latino

***Gender:**
- ☐ Male
- ☐ Female

***Race:** (Select one or more)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

***Marital Status:**
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed, Length of Marriage ____, Date of Loss ___/___/_____

***Highest Degree or Level of School Completed:**

- ☐ No Schooling
- ☐ 1st grade
- ☐ 2nd grade
- ☐ 3rd grade
- ☐ 4th grade
- ☐ 5th grade
- ☐ 6th grade
- ☐ 7th grade
- ☐ 8th grade
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade
- ☐ 12th grade (no diploma)
- ☐ High School Diploma
- ☐ GED
- ☐ Some College, no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Specialist's degree
- ☐ Doctorate or Professional degree

***Where was this Degree or Level of School Completed?** ☐ U.S. Based Schooling ☐ Non-U.S. Based Schooling

Military Career: ☐ None ☐ Active ☐ Retired ☐ Veteran ☐ Military Dependent
Branch: _____ Rank: _____

How did you hear about Embrace New Life, LLC? ☐ Print Media ☐ Friend ☐ Facebook ☐ Google ☐ Medical Professional ☐ Family ☐ Church ☐ ReEngage ☐ Other: _____

CLIENT CONTACT INFORMATION

Address: _____
Street Address/ Apartment Number / PO Box ***City*** ***State*** ***Zip***

***County of residence:** _____ Email Address: _____

Phone 1: (_____)_____ Phone 2: (_____)_____ Phone 3: (_____)_____

EMERGENCY CONTACT INFORMATION

Name: _____
Last *First* *Middle/Former Name*

Phone 1: (_____)_____ Phone 2: (_____)_____ Relationship: _____

CLIENT STATUS and SPECIAL POPULATIONS

***Labor Force Status:** *(select one)*
- ☐ Employed
- ☐ Unemployed and looking for work
- ☐ Not in marketplace and not looking for work (e.g. homemaker, retiree, student, etc.)

***Receiving Public Assistance** *(TANF, Food Stamps)*: ☐ Yes ☐ No

***Special Populations:** *(check all that apply)*
☐ Low Income ☐ Displaced Homemaker ☐ Single Parent ☐ Dislocated Worker
☐ Learning Disabled Adult ☐ Physically Disabled Adult ☐ None of the above

Language spoken at home: _____ Home Country: _____

CLIENT THERAPY GOALS

What do you want to achieve by attending therapy?

Special Accommodations Notice

If you have a disability and desire any special accommodation please let me know how I can make your time in therapy most effective for you or any accommodation I can make to the environment or the process.

_____

_____

_____

Family System: How would you describe the family you live in *now*?

☐ Nuclear Family
☐ Blended Family
☐ Intergenerational Home

☐ Common Law
☐ 1st marriage
☐ 2nd marriage
☐ 3rd marriage

Biological Children: (Names & Age):	Step Children: (Names & Age):

Are *your* parents:
- ❑ still together
- ❑ divorced, when_____
- ❑ remarried
- ❑ unmarried
- ❑ deceased, if yes whom_____ age at death_____

Your sibling group (oldest-to-youngest) name & age: _____

Do you have good family support? ❑ Yes ❑ No From whom?_____

HEALTH INFORMATION:

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Primary Care Doctor: _____ _____
(Name) (Phone)

Please list any *chronic health* problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

_____

Medications & OTC currently taking :

_____

_____

Hours per night you normally *sleep* _____ Are you having any *problems* with your sleep habits? ❑ Yes ❑ No

If yes, check where applicable: ❑ Sleeping too little ❑ Sleeping too much ❑ Can't fall asleep ❑ Can't stay asleep

Do you *exercise* regularly? ❑ Yes ❑ No

If yes, how many times per week do you exercise? _____ For how long? _____

If yes, what do you do?_____

Are you having any difficulty with *appetite* or eating habits? ❑ Yes ❑ No

If yes, check where applicable: ❑ Eating less ❑ Eating more ❑ Bingeing ❑ Purging

Have you experienced significant *weight* change in the last 2 months? ❑ Yes ❑ No

Do you regularly use *alcohol*? ❑ Yes ❑ No

If yes, what is your frequency?

❑ once a month ❑ once a week ❑ daily ❑ daily, 3 or more ❑ intoxicated daily

How often do you engage in recreational *drug* use? ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

If you checked any box other than "never," which drugs do you use? _____

Do you smoke *cigarettes*? ❑ Yes ❑ No If yes, how many cigarettes per day?_____

Do you drink *caffeinated* drinks? ❑ Yes ❑ No If yes, # of sodas per day_____ cups of coffee per day_____

Have you ever had a *head injury*? ❑ Yes ❑ No

If yes, when and what happened?_____

PSYCHOLOGICAL INFORMATION:

What or who prompted you to seek therapy or an assessment at the current time?

_____

_____

In the last year, have you experienced any significant *life changes or stressors*?

_____

_____

Have you had previous *psychotherapy*? ❑ Yes ❑ No

If yes, what was the therapeutic issue(s)? _____

If yes, when and who was your practitioner? _____

Are you <u>currently</u> taking prescribed *psychiatric medications* (antidepressants or others)? ❑ Yes ❑ No

If Yes, please list names and doses: _____

If No, have you been previously prescribed psychiatric medication? ❑ Yes ❑ No

If Yes, please list names, dates and if they were tolerable: _____

Are you hopeful about your *future*? ❑ Yes ❑ No

Are you having current suicidal *thoughts*? ❑ Frequently ❑ Sometimes ❑ Rarely ❑ Never

If yes, have you recently done anything to hurt yourself? ❑ Yes ❑ No

Have you had suicidal *thoughts* in the past? ❑ Frequently ❑ Sometimes ❑ Rarely ❑ Never

If you checked any box other than "never", when did you have these thoughts?_____

Did you ever act on them? ❑ Yes ❑ No

Are you having *current* homicidal thoughts (i.e., thoughts of hurting someone else)? ❑ Yes ❑ No

Have you previously had homicidal thoughts? ❑ Yes ❑ No If yes, when?_____

Are you **currently** experiencing:			Rating Scale 1-10 (10 =worst) *Only rate the areas to which you say "yes"*
Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Rapid Speech	yes	no	_____
Racing Thoughts	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
Panic Attacks	yes	no	_____
Phobias	yes	no	_____
Sleep Disturbances	yes	no	_____
Hallucinations	yes	no	_____
Paranoia	yes	no	_____
Poor Concentration	yes	no	_____
Alcohol/Substance Abuse	yes	no	_____
Frequent Body Complaints (e.g., headaches)	yes	no	_____
Eating Disorder	yes	no	_____
Body Image Problems	yes	no	_____
Repetitive Thoughts (e.g., Obsessions)	yes	no	_____
Repetitive Behaviors (e.g., counting)	yes	no	_____
Poor Impulse Control (e.g., ↑ spending)	yes	no	_____
Self Mutilation	yes	no	_____
Sexual Abuse	yes	no	_____
Physical Abuse	yes	no	_____
Emotional Abuse	yes	no	_____

Have you experienced in the **past**:			Rating Scale 1-10 (10 =worst) *Only rate the areas to which you said "yes"*
Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Rapid Speech	yes	no	_____
Racing Thoughts	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
Panic Attacks	yes	no	_____
Phobias	yes	no	_____
Sleep Disturbances	yes	no	_____
Hallucinations	yes	no	_____
Paranoia	yes	no	_____
Poor Concentration	yes	no	_____
Alcohol/Substance Abuse	yes	no	_____
Frequent Body Complaints (e.g., headaches)	yes	no	_____
Eating Disorder	yes	no	_____
Body Image Problems	yes	no	_____
Repetitive Thoughts (e.g., Obsessions)	yes	no	_____
Repetitive Behaviors (e.g., counting)	yes	no	_____
Poor Impulse Control (e.g., ↑ spending)	yes	no	_____
Self Mutilation	yes	no	_____
Sexual Abuse	yes	no	_____
Physical Abuse	yes	no	_____
Emotional Abuse	yes	no	_____

LEGAL INFORMATION:

Do you have any *legal* concerns? ❑ Yes ❑ No

If yes, please explain:_____

FAMILY MENTAL HEALTH HISTORY:

Research has shown that heredity plays a role in many disorders. Please take time to think of your various blood related relatives. Indicate any who have had similar symptoms as yourself.

Difficulty		Family Member(s)
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____
Psychiatric Hospitalizations	yes/no	_____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

SIGNATURE_____ DATE_____