kp counseling

INTAKE ASSESSMENT
Client Questionnaire

Date: _____

Name: _____ DOB: _____/_____/_____

Address:_____(city/state/zip)_____

Medical History

Primary Care Physician: _____ Phone: _____
Address: _____
Last Medical Exam: _____
List any medical problems that you are currently experiencing:

_____
_____
_____

List any medications you are currently taking (including over-the-counter and herbal/vitamins):

_____
_____
_____
_____

List any allergies: _____
_____

What recreational drugs/alcohol have you used in the past 6 months and how often?

_____
_____
_____

List any past medical condition or hospitalization that may be relevant to your current state of wellness._____
_____
_____

Psychiatric History

____Have you ever been treated (inpatient or outpatient) for drug or alcohol use

____Have you ever been hospitalized for stress or a psychiatric condition

____Have you ever been hospitalized for a medical condition

____Are you concerned about your alcohol or drug use

____Has anyone ever expressed concern about your alcohol or drug use

____Have you ever taken or been prescribed drugs to treat stress, anxiety, depression or a psychiatric condition

Have you ever been treated for a psychiatric illness? _____
If yes, by whom: _____ When: _____

Diagnosis:	Medications tried:
_____	_____
_____	_____
_____	_____

What symptoms or problems in the past led you to seek out a psychiatrist? _____
_____

Have you ever seen a counselor/therapist before? _____
If yes, who: _____ When: _____
What did you like about counseling/therapy? _____
_____
What did you dislike about counseling/therapy? _____
_____

Once a plan of treatment is agreed upon, may we inform your Medical Doctor/Psychiatrist to better coordinate your treatment? _____

Family history and current family information

Now or in the past, did anyone in your family (including parents, siblings, children, aunts or uncles, grandparents) have any of the following:

___Alcoholism/substance abuse or other problems with addiction
___Mental illness
___Anxiety
___Depression
___Long lasting or repeated physical illness
___Is there (or has there ever been) any physical, emotional or sexual abuse in the family?

	Age	Occupation	Describe Relationship
Father:	_____	_____	_____
Mother:	_____	_____	_____
Step-Father:	_____	_____	_____
Step-Mother:	_____	_____	_____
Brother(s):	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sister(s):	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Social History

_____ Married (number of times) _____ _____ Divorced _____ Single _____ Widowed
_____ Living with someone _____ Separated
In general, how would you describe your relationship with your partner?_____
_____
Children (indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Age	Gender	School (grade)	P?

In general, how would you describe your parenting ability? _____
_____
_____

How do you and the other parent of your child/children parent as a team? _____

Any difficulties? _____

What is the highest grade you completed?_____ GED?_____
Occupation: _____ Employer: _____
Job satisfaction: _____ love it _____ like it _____ mild dislike _____ hate it
Have you had any major changes in the last year, positive or negative, such as a death in the family, divorce or marriage, a move, starting or ending of a job? _____
If yes, please elaborate: _____

What problem(s) led you to seek counseling today? _____

How long has this problem(s) been going on? _____

How is this problem(s) affecting you? _____

What do you hope to accomplish through counseling? (what 2-3 problems would you like to see made better? _____

How many appointments do you think will be required to accomplish the goals stated above?
____ 1 - 5 ____ 6 - 10 ____ 11 - 20 ____ Other (please specify)_____