Clinical Intake Assessment

Hickory Grove Counseling Center
7200 E WT Harris Blvd.
Charlotte, NC 28215
Phone: 704-531-4034
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Name: _____DOB: _____
Reported by: _____
Interview Dates: _____

Identifying Information:
Age: _____ School/Workplace: _____
Grade/Position: _____
Phone Number: _____
Address: _____
_____
Marital/Relationship Status: _____

Psychosocial:
Race/Ethnicity, Culture, Social, Factors:
_____
_____
_____
_____
Living Arrangement (including names and ages of people living in household):
_____
_____
_____
_____
Sexual Experience History:
_____
_____
_____
Childhood History:
_____
_____
_____
_____
_____
_____

Diagnosis Information:

Admitting Diagnosis, DSM IVTR (if available):

_____

_____

Most recent evaluations and assessments completed (please provide copies of psychiatric assessments, if applicable):

_____

_____

Current Diagnosis:

_____

_____

Presenting Problem:

First noticed: _____

Problem Description:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Steps tried to resolve problem:

_____

_____

_____

_____

_____

Has anything worked/What has worked (to some extent):

_____

_____

_____

_____

_____

Mental Health Information:

Family History of Mental Illness or Substance Abuse:

_____

_____

Client History of Mental Illness or Substance Abuse:

_____

_____

Client History of Mental Health Treatment:

_____

_____

Client History of Previous Psychiatric Hospitalization:

_____

_____

History of Medications (Approximant date taken and name of medication):

_____

_____

Current Medications:

_____

_____

Family and Social History, including current circumstances and special needs that may impact therapy:

Previous living situations (Include previous moves, reasons why moved):

_____

_____

Biological Parent's involvement:

_____

_____

Step Parent's involvement (if applicable):

_____

_____

Family Composition (including custodial and non-custodial parent):

_____

_____

Parent's Marriage status (including dates of separation and divorce if applicable):

_____

_____

Reason for separation/divorce (if applicable):

_____

_____

Mental Status:

Mood/Affect (Check all that apply and explain):

- Euphoria/elated _____
- Irritable _____
- Pleasant _____
- Angry _____
- Hostile _____
- Anxious _____
- Depressed _____
- Sad _____
- Blunted _____
- Other _____

Daily Patterns (Check all that apply and explain):

- Increased Appetite _____
- Decreased Appetite _____
- Binging _____
- Purging _____
- Increased sleep need _____
- Decreased sleep need _____
- Poor quality sleep _____
- Fatigue _____
- Nightmares _____
- Social withdrawal _____
- Other _____

Thought/Perceptual Content (Check all that apply and explain):

- No Items reported _____
- Hallucinations Check Type: ___Auditory ___Visual ___Olfactory ___Tactile
- Delusions Check Type: ___Paranoid ___Grandiose ___Bizarre ___Homicidal ___Suicidal ___Self Harm
- Ideas of reference Check Type: ___Ideation ___Urges ___Plans (last 48 hours)
- Comments: _____
  _____

History of Client's Harmful Behavior (Check all that apply and explain):

- Suicide _____
- Violence _____
- Self Harm _____
- Risky Sexual Behavior _____
- Other _____

History of Harmful Behaviors in Client's Support Network (Witnessed, experienced in home, behaviors directed toward client, etc.):

- Suicide _____
- Violence _____
- Homicide _____
- Self Harm _____
- Substance Abuse _____
- Other _____
- Neglect _____
- Verbal Abuse _____
- Physical Abuse _____
- Sexual Abuse _____

History Of Grief and Loss:

Explain any loss experienced by the client or family that may affect the client (IE. Death, miscarriage, etc.…):

_____

_____

_____

Explain how client and/or family dealt with the loss:

_____

_____

_____

Describe current daily activities of client:

- Sunday _____
- Monday _____
- Tuesday _____
- Wednesday _____
- Thursday _____
- Friday _____
- Saturday _____

Describe prior and/or current drug/alcohol use/abuse (if applicable):

Date(s) started: _____
Substance used: _____
Date(s) quit use: _____
Treatment Received: _____
Other comments: _____

Children/Adolescents/Adult Past:

Academic Difficulty (Include grades, issues in certain subjects, etc.…):

_____

_____

Behavior Problems at School (With authority figures such as teachers, principles, etc.…):

_____

_____

Developmental Difficulty (Past and present issues with meeting developmental markers):

_____

_____

Peer Relationship Problems:

_____

_____

Behavior Issues at Home:

_____

_____

Discipline Techniques used by Parent(s)/Guardian(s):

_____

_____

Sexually Active? _____ Age of 1st sexual experience: _____

Parents' thoughts on the subject of sex:

_____

_____

_____

Legal: *(Please provide most recent custody or court summary to therapist)*

- Custody Agreement (IE, Joint, Primary, etc.): _____
- Custody is with: _____
- Resident is with: _____
- Visitation schedule: _____

  _____
- Who has medical making ability: _____
- Is DSS Involved? (If so, why?):

  _____

  _____

  _____
- Court Involvement (If so, why?):

  _____

  _____

  _____
- Court hearings pending: _____

Medical:

Any Past or Current Medical Issues: _____

_____

_____

Hospitalizations: _____

Date of last Physical Exam: _____ Doctor's Name: _____

Any issues found at appointment: _____

_____

Females:

- Age of first menstrual cycle: _____
- Issues associated with menstrual cycle: _____

  _____
- Birth Control? _____ What Kind? _____

  Age client started taking birth control: _____
- Is client pregnant? _____ Due date: _____

Nutrition/Physical Activity:

Eating Schedule:

_____

_____

Vitamins (if so, what kind):

_____

_____

Adequate Fluid Intake (what does client drink, any dehydration issues):

_____

_____

Is client following a special diet? (If so, give the purpose and a description of the diet):

_____

_____

_____

Any weight change? (If so, explain why so):

_____

_____

Exercise Schedule (Include activity, how many times per week, and duration):

_____

_____

Religion/Spiritual Orientation:

Client's Spirituality/Religion: _____

Brief Spiritual/religious history (if applicable): _____

_____

_____

_____

Importance in client's life: _____

How does it currently affect client's life? _____

_____

_____

_____

_____

_____

Church, Synagogue, Mosque, Temple, or any other place you attend for religious/spiritual purposes: _____

_____

How often/How involved? _____

_____

_____

Do you want this to be a part of counseling? _____

If so, How? _____

_____

_____

_____

_____

_____

_____

Why did you choose a counselor at Hickory Grove? _____

_____

_____

_____

_____

Goals of Therapy (What you want to get out of therapy):

1. _____
   _____
2. _____
   _____
3. _____
   _____

Therapist Conclusions (To be completed by the therapist after assessment):

_____
_____
_____
_____
_____

Client Signature: _____

Guardian Signature: _____

Therapist Signature: _____

Date completed: _____