FaithWorks Counseling
10505 Wayzata Blvd, Suite 101
Minnetonka, MN 55305
Fx: 952-746-8128

ADULT INTAKE

Personal History Diagnostic Assessment

Anchor Counseling
110 1st Street E.
Jordan, MN 55352
Fx: 952-492-7885

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Client Identification Data					
Name (Last)	(First)	(M)	Age	Birthdate	Sex
Address					
Cell phone: OK to call? Y N	Home Phone: OK to call? Y N	Work Phone: OK to call? Y N			
Marital Status Single Married Divorced Separated Widowed	Religion				
Education (Highest Grade Completed)	College Degrees	Veteran Yes No			
Employer	Occupation	How long employed?			

Family History						
Family Members	**Age**	**Emotional Problems**		**Living?**		**Occupation**
		Yes	**No**	**Yes**	**No**	
Spouse's Name						
Mother's Name						
Father's Name						
Stepmother's Name (if applicable)						
Stepfather's Name (if applicable)						
Other significant person responsible for raising you						

Number of children of person completing form	Age of oldest	Age of youngest	Number deceased
Number of brothers and sisters	Age of oldest	Age of youngest	Number deceased
Number of other persons living in current household	Relationship		
Notify in case of emergency (Name, relationship, phone number for contact)			
Address	Home Phone		

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Name:____ Date:__________________

Health Data

Your Physician (Full Name):____

(Street) (City) (State/Zip)

Address (Clinic Name):____

Date of most recent physical: ____

Do you have any current medical problems (including any infectious diseases)? Yes No Please describe:

____

Are your medical problems being treated? ___________If yes, by whom? _____________________

Have you ever had a drug allergy or sensitivity? Yes No If yes, to what drug:_______________

Have you ever seen any of the following for help with a problem? Please check all that apply:

Psychiatrist Psychologist Social Worker Counselor Minister Chemical Dependency Counselor

For what?_________________________When?_________________

Previous psychiatric or chemical dependency hospitalization: Yes No

If yes, where?_________________________When? _________________

____

Are you currently or have you in the past been diagnosed and/or treated for? (Please check all that apply)

stroke	seizures	migraines	liver damage	thyroid problems
anemia	chronic fatigue	diabetes	chronic pain	urinary tract infection
asthma	hepatitis	tuberculosis	eating disorder	persistent flu-like symptoms
cancer	hypertension	menopause	perimenopause	poly-cystic ovarian syndrome
cardiac problems	communicable diseases			

Other: ____

Chemical Use History

Do you drink alcoholic beverages? Yes No If yes, what do you drink? Beer Wine Hard liquor

How often do you drink? Daily 3-5 times weekly 1-2 times weekly Less frequently

Do you sometimes drink more than you had planned? Yes No

Have family and friends ever expressed concern about your drinking? Yes No

Have you ever been arrested for alcohol related charges: DWI, public intoxication etc.? Yes No

Have you ever been treated for drinking, chemical dependency or gone to AA? Yes No

Have you ever had periods where you were unable to remember what happened when you were drinking? Yes No

Have you ever overdosed? Yes No

Do you use nicotine? Yes No If yes, how much and for how long: _______________________

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Client's name:____Date(s)________________

Parent/Guardian:____

Presenting situation: (include reason for making appointment, precipitating events, onset, course of symptoms)

____
____
____
____
____
____
____
____
____
____
____

Suicidal/homicidal ideation/attempts (include current/past, note plan, intent, safety plan, previous methods/outcomes)

Currently experiencing suicidal thoughts: No Yes (note additional information below)

History of suicidal thoughts/attempts: None Yes (note additional information below)

____
____
____
____

Medications:

Current Meds: ____

____

Prescribing MD:____

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Past trials of psychiatric meds:____

____

Intake/Diagnostic Assessment **Client:**___________________________________

Symptom:	**Yes**	**No**	**Additional info/duration and/or ex. of impairment**
Mood: Depressed			
Elevated			
Cyclic			
Sleep: Delayed Onset			
Interrupted			
Early Awakening			
Hypersomnia			
Decreased need			
Appetite: Decreased/weight loss			
Increased/weight gain			
Interest in Activities: Decreased			
Increased			
Energy: Decreased			
Increased			
Psychomotor: Agitated			
Retardation			
Sexual Interest: Decreased			
Increased			
Low concentration/indecisiveness			
Hopelessness/helplessness			
Worthlessness/guilt			
Crying			
Self-mutilation/cutting			
Suicidal thoughts or thoughts of death			Intent to act(0-10, 10=high intent, 0=no intent)
Exploring plan or plan made			
Past attempts/gesture			
Homicidal thoughts			
Anger			
Dsythmia: 2 yrs of depressed mood			
Low self-esteem			
Symptoms absent <2 months			
Manic: Grandiosity/inflated self-esteem			
More talkative/pressure speech			
Flight of ideas/racing thoughts			
Distractibility			
Increase in goal-directed activity			List:
Increase in pleasurable activities			
Eating Disorder: (If yes, see ED Intake)			
Impulsivity Thoughts (reactive)			
Behaviors (gambling/shopping/other)			
Hallucinations			Auditory Visual Olfactory Gustatory Tactile
Delusions			Thought control/insertion Media messages Special Powers Grandiose Persecution Thought Broad-casting Somatic

==

Intermittent Explosive: Assaults/destroys property Aggressiveness not proportional to stressor			

Intake/Diagnostic Assessment **Client:**______________________________________

Symptoms	Yes	No	Additional info/duration and/or ex. of impariment
Generalized anxiety: Excess anxiety/worry			**List topics of worry:**
Worries more days than not			
Difficult to control the worry			
Restlessness/on edge			
Easily Fatigued			
Concentration low/mind goes blank			
Irritability			
Muscle tension			
Sleep disturbance			
Panic Attacks: Sweating			
Palpitations/accelerated heart			
Trembling/shaking			
Shortness of breath/smothering			
Feeling of choking			
Chest pain/discomfort			
Nausea/abdominal distress			
Dizzy/Lightheadedness/faint			
Derealization/depersonalization			
Parasthesia (numbing/tingling)			
Chills or hot flashes			
Fear of losing control/going crazy			
Fear of dying			
Specific Phobias			
Social Phobia: social/performing anxiety			
Fears of scrutiny or embossing self			
Recognizes fear is excessive			
Avoid situations/endure with distress			
PTSD: Witnessed trauma to self/other			
Fear/helplessness/horror response			
Recurrent/intrusive recalling of event			
Recurrent distressing dreams			
Acting/feeling as if event is recurrent			
Distressing at exposure to cues of event			
Physiological reactivity (exposure to cue)			
Avoidance or numbing of responsiveness			**Check: Avoid:** thoughts feeling conversation activity places people
Persistent increased arousal			**Check:** sleep irritability anger hypervigilance concentration trouble exaggerated startle

Obsessive/Compulsive Disorder			
Recurrent thoughts/impulses/images			
Experienced intrusive/inappropriate			
Causes marked distress/anxiety			
Tries to ignore/suppress with action/thought			
Recognizes as product of own mind			
Repetitive behaviors driven to perform			**Check:** washing counting checking praying ordering repeating words silently other:
Aimed at preventing/reducing distress			

Intake/Diagnostic Assessment **Client:**______________________________________

Previous episodes of presenting issue: (include precipitating event(s), variations of (symptoms/severity/duration/tx, etc)

____

____

____

____

Counseling and psychiatric history: (dates of trtmnt, hospitalization, provider and outcomes, etc.)

Outpatient IOP(Partial hospitalization) Inpatient hospitalization Residential

Additional Info:____

____

____

____

____

Chemical use history and treatments: (past/present use, age started to use and problem behavior include nicotine use)

Alcohol use: No Yes Past If yes, frequency________________ Quantity:______________________

Drugs: No Yes Past If yes, frequency________ Quantity:________ Drug Type:________________

Nicotine: No Yes If yes, quantity and duration:____

Note any usage difference in the past and any other pertinent information:______________________________

____

____

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Physical health: **(any current/past illness/head injury. Adolescents include prenatal events, childhood diseases, dev. issues)**

____

____

____

Other factors that impact client's life **(e.g. cultural issues, military, spiritual and/or legal issues)**

Legal issues: No Yes (describe if yes)______________________________

____

Military: No Yes (describe if yes)______________________________

Cultural issues: No Yes (describe if yes)______________________________

Spiritual beliefs/practices:______________________________

Intake/Diagnostic Assessment **Client:**______________________________

Abuse History

Hx of abuse: Yes No If yes: physical sexual verbal/emotional **Legal Action:** Yes No

By:______________________________

When:______________________________

Family Mental Health History: (include family hx of suicide/homicide)

Maternal side: depression anxiety bipolar eating disorder alcoholism drugs suicide

Paternal side: depression anxiety bipolar eating disorder alcoholism drugs suicide

Additional information: (who, treatment, other diagnoses, etc.)

____

____

____

____

____

Current Family and Significant Relationships: (Marital status, children, friendships, support people)

Single Widow/widower Divorce Married Multiple Marriages (note details below) Dating

____# Children: Sex/age/grade: ______________________________

____# Step-children/half-children: Sex/age/grade:______________________________

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Who lives in the home with you:____

If Female (check if yes): miscarriages abortion If yes, note # and when:__________________

Friendships/support people:____

____

____

____

Intake/Diagnostic Assessment **Client:**__________________________

Family of Origin Information

Parents living: **Dad** Yes No **Mom** Yes No

Parents divorced: Yes No If yes, client was how old?_______________________

If divorced remarried: **Dad** Yes No **Mom** Yes No

Mom described as:____

____

____

Dad described as:____

____

____

Parents Occupation: **Dad**______________________ **Mom**______________________

Sibling:____

____

____

Other:____

____

Educational/Vocational/Social History:

Highest level of education completed: ___________________________________

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Performance: Average grades/GPA: _______ Learning Disabilities: No Yes If yes, describe:

____

Client's perspective on educational experience:_________________________________

____

Social/activity involvement in school:____

____

Other (Dev. Issues during adolescent):____

____

Occupation

Current employer and position:____

____

Job history:____

____

____

____

Signature:____ Date:________________

I have reviewed the Assessment & Diagnosis:

Intake Therapist's Signature: ____________________________________ Date: ________________

Supervisor (If Appropriate): _____________________________________ Date: ________________

(Please do not write here. For therapist's use)

Revised 5/11/20