Case Number: ________________

Family Counseling and Children's Services of Lenawee County

Adult Intake Assessment

Client's Name: ____ Date of Intake: ___________

Gender: _____________ Date of Birth: _______________ Age: __________

Please answer questions in the unboxed areas of the form only.

Primary reason(s) for seeking services at this time (please check all that apply):

____ ADHD ____ Eating Disorder ____ Relationship Issues

____ Anxiety ____ Grief ____ Substance Abuse

____ Depression ____ Repeated Behaviors ____ Traumatic Experience

Other mental health concerns (specify):

____

Current Life Stressors (please check all that apply):

____ Children ____ Finances ____ Legal Issues

____ Environment ____ Health ____ Relationship

____Family ____ Job ____ School

Other life stressors you are currently experiencing (specify):

____

Shaded area for therapist use only

Relationship and Family Information

Relationship Status:

____ Single ____ Engaged ____ Married ____Living Together ____ Divorced ____Widowed

Sexual Orientation: ___________________________

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

Have you experienced physical, sexual, emotional, economic or psychological abuse in current or past relationships?

____ Yes ____ No

Environmental Information:

Children/Stepchildren:

Name	Sex	Age	Currently Living with you (Y/N)

Other Individuals Living in Your Household:

Name	Sex	Age

With whom did you live while growing up? ____

Number of Siblings: _______ Your place in birth order: _____________

Parent's present marital status: ____

Describe your current relationship with your:

Father____

Mother____

Siblings____

____

Social Relationships:

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/Argue Often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/Withdrawn ____ Submissive

____ Other (specify): ____

Is there anyone in your life that you feel you can talk with about your situation? ____ Yes ____ No

Spirituality:

Is spirituality an area of support or strength for you? ____ Yes ____ No

Are you currently affiliated with a spiritual or religious group? _____ Yes _____ No

If yes, describe: ____

Are you content with your level of activity in regards to spirituality? _____ Yes _____ No

Education:

Fill in all that apply:

Are you currently enrolled in school? _____ Yes _____ No

_____ High School Graduate/ GED

_____ Vocational School: Number of years: _____ Graduated: _____ Yes _____ No Major: ___________________

_____ College: Number of years: ______ Graduated: _____ Yes _____ No Major: ___________________

_____ Graduate School: Number of years: _____ Graduated: _____ Yes ______ No Major: ___________________

Other training:

____

Special circumstances (learning disability, gifted, etc.): ____

Employment:

Are you currently employed? ____ Yes ____ No

Employed Full Time ____ Employed Part Time ____ Seasonal Employment ____

Disabled ____ Retired ____ Student ____ Other (describe): ____________________

Legal:

Are you involved in any active cases (civil, criminal)? ____ Yes ____ No

If yes, please describe and indicate the court and hearing/trial dates and charges: ____________________

____

Are you currently on probation or parole? ____ Yes ____ No

If yes, please list your officer's name: ____

Over the past 10 years, do you have a history of any of the following:

Traffic violations: ____ Yes ____ No DWI, DUI: ____ Yes ____ No

Criminal Involvement: ____ Yes ____ No Civil Involvement: ____ Yes ____ No

Domestic Violence: ____ Yes ____ No

Medical/Physical Health:

List any current physical health concerns: ____

____

____

____

Current prescribed medications	Dose	Purpose	Side Effects
____________________	_____	____________	________________
____________________	_____	____________	________________
____________________	_____	____________	________________
____________________	_____	____________	________________

Most recent examinations	Date	Reason	Results
Last physical exam	_______	______________	____________________
Last doctor's visit	_______	______________	____________________

Family history of medical problems (describe): ____

____

____

Have you ever had a head injury? ____ Yes ____ No

Do you have a current issue or past history of self-injury (cutting, burning, etc.)? ____ Yes ____ No

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General mood ____ Weight ____ Nervousness

Mental Health:

Have you ever participated in counseling before? _____ Yes _____ No

If yes, who was your treatment provider? ____

Have you ever been involved with self-help groups? _____ Yes _____ No

If yes, what topic? ____

Have you ever been hospitalized for issues related to mental health? _____ Yes _____ No

If yes, when and where? ____

Have you ever had thoughts of suicide or made attempts at suicide? _____ Yes _____ No

Do you feel suicidal at this time? _____ Yes _____ No

Have you ever experienced homicidal thoughts? _____ Yes _____ No

Do you feel homicidal at this time? _____ Yes _____ No

Is there a family history of mental illness? _____ Yes _____ No

If yes, please describe: ____

____

____

Substance Use:

Do you use alcohol? ____ Yes ____ No

If so, how many drinks per day _____________ per week _____________ per month _____________

Have you ever felt the need to cut down on your drinking? ____ Yes ____ No

Have others ever told you need to cut down on drinking or drug use? ____ Yes ____ No

Have you ever experienced memory issues after drinking? ____ Yes ____ No

Which drugs (not medications prescribed for you) have you used in the last 10 years?

____

____

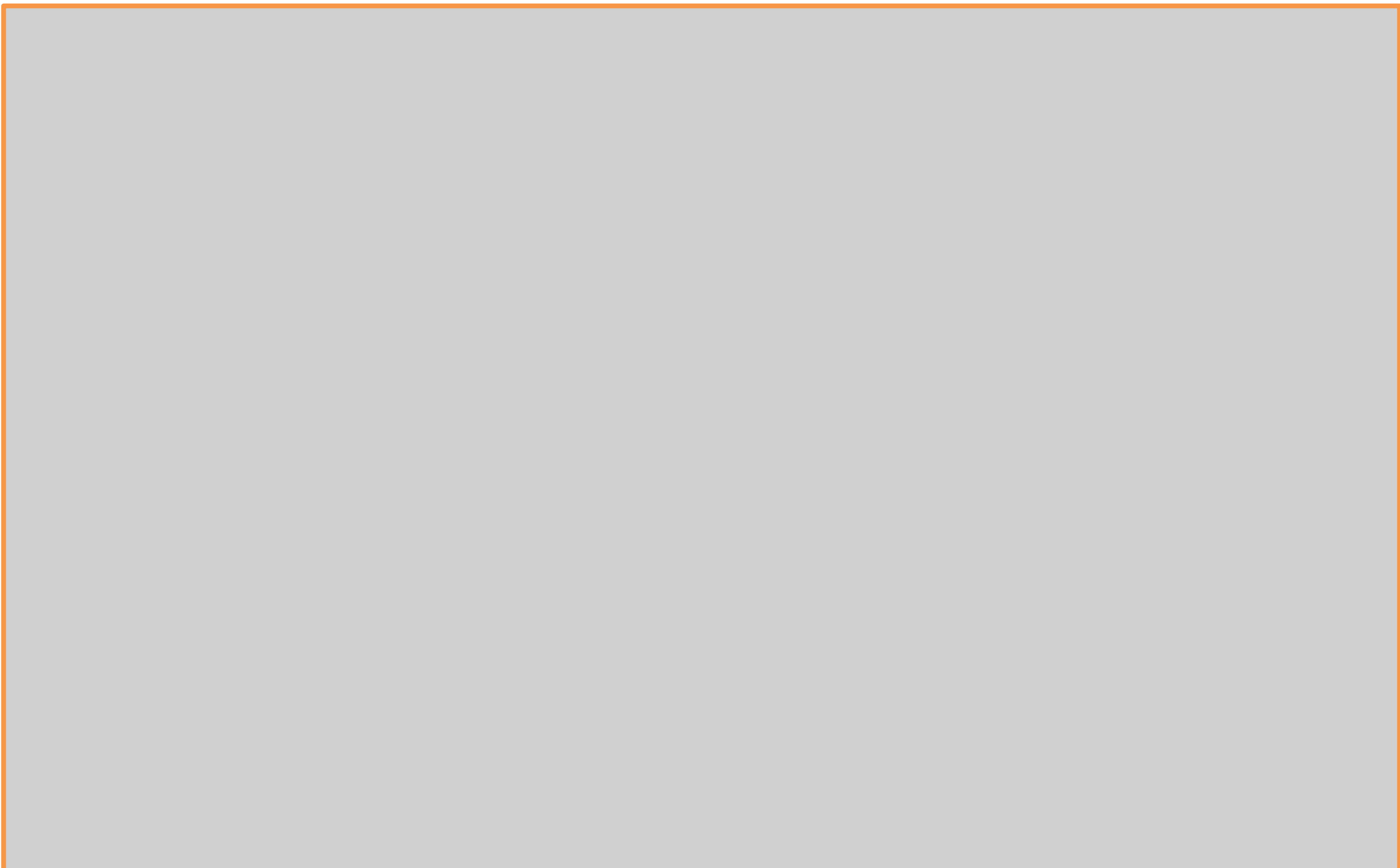
____

Are you currently using drugs (not medications prescribed for you): ____ Yes ____ No

Have you ever participated in substance abuse counseling? ____ Yes ____ No

If yes, who was your treatment provider? ____

Do any of your family members have a drug or alcohol problem, past or present? ____ Yes ____ No



MENTAL STATUS:

General Behavior: Cooperative, passive, withdrawn, hostile, anxious, other___________________________

Attire: Appropriate, seductive, untidy, loud, meticulous, other____________________________

Gait: Normal, erect, stooped, rigid, shuffling, other______________________________________

Motor Activity: Normal, agitated, retarded, tic, mannerism, other_________________________________

Stream of thought and communication:

Productivity: Spontaneous, verbose, pressured speech, unproductive, other____________________

Progression: Normal, loose, halting, incoherent, fragmented, other_____________________________

Language: Normal, baby talk, rambling, impediment, verbose, profane, other _______________

Emotional tone and reactions:

Mood/Affect: Indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, normal composed, anxious, tearful, depressed, other_______________________________________

Mental Trend/Content of thoughts:

Perception: Normal, auditory, hallucinations, visual hallucinations, illusions, depersonalization, delusions of grandeur, other____

Orientation: Normal, disoriented to time, place, person, other_________________________________

Memory: Normal, defective, (remote, recent, immediate)

General Knowledge: Consistent with education, inconsistent, explain if needed:_______________________

Insight: Absent, good fair, minimal

Judgment: Good, fair, poor

Diagnostic Summary:

DIAGNOSTIC IMPRESSIONS (DSM-5 Code and Diagnosis)

____

____

____

____

____

METHOD OF DATA COLLECTION: □ **Client Self Report** □ **Clinical Observation**
□ **Self-Rating Scale** □ **Court Report**
□ **Other:** ____

Document all unmet needs and service gaps and provide an explanation for needs/problems that have not been addressed and referrals that have been made:

____

____

____

Indicate all those who have been involved in services planning for this client.

____

____

____

INITIAL PROBLEM AREA/NEED: ____

____

____

____

TREATMENT GOAL: **TARGET DATE**

____

____

____

____

OBJECTIVES:

____

____

____

____

____

INTERVENTIONS:

____

____

____

____

Service recommendations: ☐ **Brief solution based (5-10 sessions)** ☐ **Long term therapy (10+ sessions)**

- ☐ **Individual**
- ☐ **Group**
- ☐ **Couples**
- ☐ **Family**
- ☐ **Pregnancy counseling**
- ☐ **Other:** ___________________________
- ☐ **Counseling for recent trauma victim (may need more frequent monitoring)**

Client's comments:

____

____

Does the client agree with the IPS ☐ **Yes** ☐ **No** ☐ **Cannot determine**
Psychiatric consult requested ☐ **Yes** ☐**No**
I hereby authorize Family Counseling and Children's Services to provide the above services.

____ ___________________
Parent/Guardian Signature **Date**

____ ___________________
Client's Signature **Date**

____ ___________________
Therapist Signature **Date**

Supervisor's comments:

____

____

____ ____________________
Supervisor's Signature **Date**