

Clinician Intake Form

Client Name: D.O.B: Today's Date:

Program and Service Name:

Provider: Location:

Start Time: End Time: Duration: mins

Modality:

Additional Service:

Mobile Phone Number: Email:

Who completed the client intake form?

If other who?

Session Conducted Via: In-Person Telehealth

If telehealth, client physical location: Home Other

If other, client physical location (Full Address)

If telehealth, clinician physical location (City, State)

Appointment Availability:

Preferred locations (Check all that apply):

What type of service are you seeking

Referral Source

How did you hear about us?

Mental Health History

Previous mental health treatment: Yes No

If yes, for what?

If other, what type?

Additional Clinical Comments:

Previous mental health diagnosis: Yes No

If yes, for what diagnoses?

other mental health diagnoses.

Family history of mental illness: Yes No

If yes, for what diagnoses?

Client reported his mother being diagnosed with anxiety and depression. Client reported his father being diagnosed with bipolar disorder. Client denied other family history of mental illness.

Current psychotropic medications:

Client discussed taking Zoloft; 50 mg. Client reported being prescribed this in April of 2020 by his general practitioner. Client reported seeing improvements in his symptoms of depression after starting this medication.

Medical History

Current medical concerns: Yes No

If yes, what concerns?

Client discussed being diagnosed with asthma at 10 years old. Client denied any other medical diagnoses.

Current medications: Yes No

If yes, which ones?

Client discussed taking Albuterol for asthma as need. Client denied taking other medications.

Family history of medical conditions: Yes No

If yes, what conditions?

Client discussed his father having high blood pressure. Client denied other family history of medical conditions.

When did client reach developmental milestones (e.g., walking, talking, toilet training, etc.)?

Early On time Late Unsure

Additional Clinical Comments:

Client discussed reaching his developmental milestones at an average rate. Client denied any developmental difficulties.

Social History

Highest level of education:

some college

Additional Clinical Comments (e.g., current grade, type of degree, type of trade, school performance, stress levels, etc.):

Client discussed attending Indiana University Northwest in 2011. Client discussed going to school for Mechanical Engineering. Client discussed completing his freshman and sophomore year. Client discussed having to withdraw from classes his junior year due to financial stress. Client discussed long-term goal of finishing his degree.

Employment status:

full-time

Additional Clinical Comments (e.g., Stress levels, place of employment, disability benefits, etc.):

Client reported he works full-time at Crew Carwash as a manager. Client discussed working are Crew Carwash for 4 years. Client discussed low job satisfaction due to conflict with co-workers, financial stress, and high stress levels when communicating with customers.

Living Situation:

Apartment

Additional Clinical Comments (e.g., who they live with, describe home life, etc.):

Client reported living in an apartment with his girlfriend. Client discussed long-term goal of owning a home. Client reported living with his girlfriend for the past 3 years and discussed enjoying this.

Social support system:

poor

Additional Clinical Comments:

Client discussed a minimal social support system. Client discussed having one close friend from high school. Client discussed primary support system including his girlfriend and his mother.

Father living: Yes No

How would you describe the relationship?

Client reported his father passing away in 2018. When asked to describe his relationship with his father, client stated, "We were very close. We would do anything together."

Mother living: Yes No

How would you describe the relationship?

When asked to describe his relationship with his mother, client stated, "We were very close. She is the person I feel most comfortable going to."

Do you have siblings: Yes No

If yes, how many?

Client denied having siblings.

Additional Clinical Comments:

Client reported his is an only child.

Relationship status:

single

Additional Clinical Comments (e.g., describe the relationship, how long together, etc.):

Client reported being in a significant relationship for 3 years. Client discussed a close relationship with his girlfriend. Client discussed minimal stress in this relationship and discussed long-term goals of traveling with his significant other.

Children: Yes No

If yes, how many?

Client denied having children.

If the client is a minor, is there a court ordered custody agreement?

Yes No N/A (client is 18 or older)

If yes, do you have sole or joint custody?

Sole custody Joint custody

If you share custody, please provide their name and phone number, as consent from both parents is required for treatment:

N/A

Military Service: Yes No

If yes, military status:

N/A

Substance Use History

Current substance use (check all that apply):

tobacco

Previous substance use (check all that apply):

alcohol, tobacco

If the client endorsed current substance use, obtain the following information for each substance:

Name of substance: Amount used:

Frequency: Last time of use:

Name of substance: Amount used:

Frequency: Last time of use:

Name of substance: Amount used:

Frequency: Last time of use:

Previous substance use treatment: Yes No

If yes, type of treatment:

N/A

Additional clinical comments (e.g., concerns about use, withdrawal symptoms, legal involvement relationships issues, etc.)

Client discussed smoking cigarettes since age 20yo. Client discussed wanting to quite smoking.

Legal History

Have you ever been arrested: Yes No

If yes, for what?

Client denied being arrested in the past.

Have you ever been incarcerated: Yes No

If yes, how long?

Client denied being incarcerated in the past.

Additional Clinical Comments (e.g., year, charge, etc.):

None reported.

Trauma History:

History of trauma: Yes No

If yes, please check all that apply:

other

If other, provide a brief explanation:

Client reported loss of his father in 2018 as a traumatic experience.

Additional Clinical Comments:

Client reported increase in depressive symptoms including increased sadness more often than not, difficulty sleeping, loss of interest, and passive suicidal ideation during the time of his father's passing. Client discussed distressing dreams and flashbacks related to the death of his father.

Risk Assessment

Have you ever attempted suicide?

no

Additional clinical comments (e.g., age/year, method, situation, outcome, family history, etc.):

Client denied ever attempting suicide.

History of Suicidality:

passive suicidal ideation

Additional clinical comments (e.g., describe thoughts, frequency, last time, etc.):

Client discussed past history of passive suicidal ideation without plan or intent to harm self. Client discussed onset of suicidal ideation in August of 2018; after the death of his father. Client discussed frequency of passive thoughts "once every couple days". Client discussed feelings of hopelessness during this time including thoughts such as "I don't know how this will get better." Client discussed having passive suicidal ideation from 2018-2020. Client denied current suicidal ideation.

Family history of suicide: Yes No

Additional Clinical Comments (e.g., which family member, situation, etc.):

Client denied a family history of suicide.

Self-Harming Behaviors

no

Additional clinical comments (including method, reason, last time, etc.):

Client denied a history of self-harm.

Protective Factors:

significant other
future plans
motivated for treatment

Additional clinical comments:

Client discussed protective factors including relationship with his significant other, relationship with his mother, and long-term goals he has for his future. Client stated, "I don't want to feel this way any more, I want to get help."

History of Homicidality:

denied

Additional clinical comments (e.g., identified person, describe thoughts, etc.):

Client denied thoughts of intent to harm others.

Risk factors reviewed for harm to self or others, and patient appears to be:

low

If identified as moderate or high risk, what steps were taken?

N/A

Self-Care Activities

Eating Habits:

all over the place

Dietary Choices(check all that apply):

frequent fast food/restuarant intake

Other/Additional Information:

Client discussed fluctuating appetite stating, "Sometimes I am very hungry, and other days I cannot get myself to eat anything."

Sleeping Quantity:

5-7 hours per night

Sleep Quality:

always tired

Other/Additional Information:

Client discussed feeling fatigued and having difficulty falling asleep. Client discussed getting on average 6 hours of sleep a night. Client reported it taking one hour to fall asleep and waking up at least once throughout the night.

Coping skills/Stress management:

need more

Coping skills utilized:

other

Other/Additional Information:

Client discussed current coping skills including talking with his mother and significant other. Client discussed other coping skills including taking his dog for a walk and playing videogames. Client reported desiring to work on additional coping skills.

Exercise Frequency:

infrequently

If yes,type of exercise:

walking

Other/Additional Information:

Client reported primary source of exercise including walking his dog twice a week.

Body Image:

content

Other/Additional Information:

Client reported experiencing average self-esteem/self-confidence. Client rated current self-esteem a 6/10.

Goals and Strengths

Briefly describe what you hope to accomplish with counseling:

Client reported, "I want to stop feeling so sad and lonely. It is hard to get out of bed and hard to take care of myself. I want to be happy again."

What are some of your strengths?

Client reported, "I am hard-working, caring, and when I set my mind to something, I will do it."

Anything additional you would like your therapist to know?

Client denied further detail.

Presenting Problem

What brings you in for therapy?

Client reported, "I have needed to make this call for a while. I need someone to talk to about how I have been feeling. I have been unhappy for a few years now and don't find enjoyment in life anymore."

Check all that apply:

depression, grief, trauma, crying spells, loss of interest

If other, please explain:

Client denied.

Depression Cluster

- | | |
|---|--|
| <input checked="" type="checkbox"/> Depressed mood more days than not | <input type="checkbox"/> Recurrent suicidal ideation |
| <input checked="" type="checkbox"/> Diminished interest or pleasure in activities | <input type="checkbox"/> Significant weight change |
| <input type="checkbox"/> Increased appetite | <input checked="" type="checkbox"/> Decreased appetite |
| <input checked="" type="checkbox"/> Insomnia | <input type="checkbox"/> Hypersomnia |
| <input type="checkbox"/> Psychomotor agitation | <input type="checkbox"/> Psychomotor retardation |
| <input checked="" type="checkbox"/> Fatigue or loss of energy | <input type="checkbox"/> Feelings of worthlessness |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Poor concentration |
| <input checked="" type="checkbox"/> Recurrent thoughts of death | |

Duration Less than 6 months Greater than 6 months

Additional Clinical Comments:

Client discussed history of depressive symptoms including increased depressed mood more often than not, loss of interest in doing things he previously enjoyed, difficulty falling asleep and staying asleep, decreased appetite, fatigue, and history of passive suicidal ideation. Client discussed onset of depressive symptoms in 2018 with improvement from individual therapy in 2019. Client discussed worsening of depressive symptoms within the last year.

Mania Cluster

- | | |
|--|---|
| <input type="checkbox"/> Abnormally elevated, expansive, or irritable mood | <input type="checkbox"/> Increased goal-directed activity or energy |
| <input type="checkbox"/> Inflated self-esteem | <input type="checkbox"/> Grandiosity |
| <input type="checkbox"/> More talkative than usual | <input type="checkbox"/> Flight of ideas (subjective racing thoughts) |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> High Risk Behaviors |

Duration Less than 6 months Greater than 6 months

Additional Clinical Comments:

Client denied history of symptoms of mania.

Anxiety Cluster

- | | |
|---|---|
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Restlessness |
| <input checked="" type="checkbox"/> Being easily fatigued | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Muscle tension |
| <input checked="" type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Panic attacks |

Duration Less than 6 months Greater than 6 months

Additional Clinical Comments:

Client discussed history of fatigue and sleep disturbances over the past year better explained by grief and depressive symptoms.

Disruptive Disorder Cluster

- | | |
|---|---|
| <input type="checkbox"/> Difficulty Completing Tasks | <input type="checkbox"/> Violent |
| <input type="checkbox"/> Interrupts Conversations | <input type="checkbox"/> Property Destruction |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Talks Excessively | <input type="checkbox"/> Skips work/school |
| <input type="checkbox"/> Difficulty Following Conversations | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Oppositional |
| <input type="checkbox"/> Loud | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Impulsive | |

Additional Clinical Comments:

Client denied.

Trauma Related Cluster

- History of witness learning or experiencing a traumatic event
- Intrusive distressing memories
- Recurrent distressing dreams
- Flashbacks
- Intense psychological distress to exposure or internal or external cues
- Marked physiological reactions
- Avoidance
- Inability to recall important aspects
- Negative beliefs about self, others or world
- Distorted cognitions
- Persistent negative emotional state
- Diminished interest
- Detachment
- Inability to experience positive emotions
- Irritable behavior and angry outbursts
- Reckless or self-destructive behaviors
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbances

Additional clinical comments (e.g., identified trauma/stressor, year, etc.):

Client discussed symptoms of trauma related to the passing of his father. Client discussed history of distressing memories, flashbacks, and dreams involving his father's death. Client reported onset of these symptoms in 2018 following the death of his father. Client also discussed history of sleep disturbances such as difficulty falling asleep and staying asleep. At time of intake, client did not meet enough criteria to qualify for Post-Traumatic Stress Disorder. It is advised that assigned therapist continue to assess for criteria related to this diagnosis.

Substance Use Cluster

- Often taken in larger amounts or over a longer period than was intended
- Persistent desire or unsuccessful efforts to cut down or control use
- A great deal of time is spent in activities necessary to obtain the substance
- Craving or strong urge
- Continued use despite recurrent social or interpersonal problems
- Important activities are given up or reduced because of use
- Recurrent use in situations that is physically hazardous
- Continued use despite knowledge of physical and psychological problems
- Tolerance
- Withdrawal
- Recurrent use resulting in failure to fulfill major obligations

Additional clinical comments (e.g., name of substance, etc.):

Client denied.

Obsessions/Compulsion Cluster Yes No

If yes, describe:

Client denied.

Psychosis Cluster

- Auditory hallucinations
- Delusions
- Tactile hallucinations
- Visual hallucinations
- Paranoia
- Olfactory hallucinations

Additional Clinical Comments:

Client denied.

Other

- Disordered eating habits
- Identity Concerns
- Interpersonal Relationship Concerns
- Sexual Dysfunction
- Low self-esteem
- Anger management

Additional Clinical Comments:

Client denied.

Mental Status Exam (MSE) Within Normal Limits

Appearance:

Neat

Speech:

Normal

Language:

Normal

Motor Activity:

Normal

Affect:

tearful

Attitude:

Calm and cooperative

Attention:

Normal

Mood:

depressed

Cognition:

Within Normal Limits

Memory Impairment:

None

Insight:

Good

Judgment:

Good

Perception:

None

Thought Process:

Logical and Coherent

Thought content:

Normal

Homicidality:

None

Suicidality:

Past passive suicidal ideation

Delusions:

None

Behavior:

Cooperative

Additional Clinical Comments:

Client reported past passive suicidal ideation from 2018-2020. Client denied current suicidal ideation. Assigned therapist and client should continue to monitor suicidal ideation and take appropriate action if suicidal ideation returns.

Diagnosis:

Additional supporting evidence included

-
- Based on the presenting problems reported by the client, and resources available, the client is appropriate for services at this agency at this time. Recommendations or referrals for treatment outside of this agency will

 - Based on the current level of treatment needed to address their reported symptoms, the client will be referred to an outside agency. A more comprehensive treatment team including psychiatric services, group therapy,