TRANSCENDENT Truth INC.
A CARE SYSTEM

Intake Assessment Form

Please provide the following information and answer the questions below. Please note; **Information you provide here is protected as confidential information.** Please Fill out this form and bring it to your first session.

Today's Date: ____________

GENERAL INFORMATION

Name:

____

(Last) (First)(Middle Initial)

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Birth date:____/_____/_____Age:_______Gender [ ] Male [ ]Female

Address:____

(Street and Number)

____

(City) (State) (Zip)

Home Phone: ( ) May we leave a message ☐ Yes ☐ No

Cell/Other Phone: ( ) May we leave a message ☐ Yes ☐ No

E-mail: ____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Race: ____________________

Cultural Considerations: ____

Religion: ____

Education

High School: ____

(Where) (Last grade completed) (Graduated? Y or N)

Post High School Education:
Explain:

____

____

Is or was school performance a concern for you?
If yes, explain:

____

____

Marital Status
[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Never

Years Married:______________ Years Divorced: ______________

Are you currently in a romantic relationship? ___________________________

If yes, for how long? ____

On a scale of 1-10 how would you rate your relationship? __________________

What significant life changes or stressful events have you experienced recently?____

____

____

Children:

Name	Age	Sex	Occupation or Grade	Living with Client	Biological, Adopted, or Step

Your Brothers and Sisters:

Name	Age	Biological, Adopted, Or Step

Other Household Members

Name	Age	Relationship to Client

Who currently lives in your household?

Describe your relationship with:

Parents:____

Siblings: ____

Extended Family Members: ____

Husband/Wife/Significant Other:

____

Your Children: ____

Health History

Primary Physician: ____

Primary Physicians Address: ____

Primary Physicians Phone:______________________Date of Last Exam_________________

Please List Allergies if Any____

Have you previously received any type of mental health services (Psychotherapy, Psychiatric services, ECT.)?
Yes______
No_______
If yes, when and where?

____

____

List any support groups you have attended in the past or presently:

____

____

Was support group attendance helpful?

____

____

Are you currently taking any prescription medications?
Yes_______
No________
Please list:

____

____

Have you ever been prescribed psychiatric medication?
Yes______
No_______
Please list:

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMAITON

*How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing:____

____

*How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

____

How many times per week do you generally exercise? ____________________

What types of exercise do you participate in?

____

____

Please list any difficulties you experience with your appetite or eating patterns:

____

____

Are you currently experiencing overwhelming sadness, grief, or depression?

Yes________ No_________

If yes, approximately how long? ____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

If yes, when did you begin to experience this?

____

Are you currently experiencing any chronic pain?

If yes, please describe:

____

____

Are any physical characteristics or body image a concern? Explain:

____

____

Is sexual functioning an area of concern for you? Explain:

____

____

Substance Use

Do you drink alcohol more than once a week? Yes______ No______

If yes, how often? ____

Is alcohol an area of concern for you? Yes_______ No_______

If yes, explain:

____

____

How often do you engage in recreational drug use?

Daily_____ Weekly_____ Monthly ______ Never_____

Is recreational drug use an area of concern for you? Yes______ No______

If yes, explain:

____

____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle ECT.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Abuse History

Have you experienced physical, sexual or emotional abuse? Yes____No_____

If yes, explain____

Legal History

Do you have a history of any legal charges? Yes______No_______

If yes,
explain____

____

Are you currently on probation or parole? Yes______ No______

If yes,
explain____

____

Is treatment court ordered? Yes______ No______

Employment

Are you currently employed? Yes_____ No______

If yes, what is your current employment situation?

____

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

Additional Information

What do you consider to be some of your strengths?

____

____

____

____

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

Is there anything else you feel we should know, or that you are concerned about?

X

Signature of Person Completing Form