HOPE – Child & Family Counseling, Inc.
Adult and Adolescent Intake Assessment

Date:___ / ___ / _____

Client Name: ____ DOB: ___ /___ / ____ Age: ____

Gender: ☐ Male ☐ Female ☐ Other (please specify): _____________

Address: ____

City, State, & Zip: ____

Phone Number: (____) - _____________________________

Current employment status: ____

Current grade level or highest education completed: ______________________________________

Parent(s)/Guardian (If applicable): ____

Presenting Problem:

What concerns bring you to HOPE?

How are these concerns impacting you and your daily life?

How long have these concerns been occurring?

What do you hope to achieve through therapy?

Please provide any additional information you think is important for your counselor:

Current Symptoms:

☐ Abandonment issues
☐ ACOA
☐ Aggressive Physical Behavior
☐ Aggressive Verbal Behavior
☐ Alcohol abuse
☐ Anger issues
☐ Anorexia/Bulimia
☐ Anxiety/Tension
☐ Binge eating
☐ Child problem
☐ Chronic Pain
☐ Cognitive Problems (understanding, concentrating, or remembering)
☐ Compulsive gambling
☐ Concentration Problems
☐ Conduct Problems/Disruptive Behavior
☐ Decreased Appetite
☐ Delusions
☐ Depression
☐ Diet pill misuse/abuse
☐ Difficulty concentrating
☐ Difficulty with sleep maintenance
☐ Difficulty with sleep onset
☐ Diuretic misuse/abuse
☐ Fatigue
☐ Feelings of guilt/shame
☐ Feelings of helplessness
☐ Feelings of hopelessness
☐ Feelings of worthlessness
☐ Financial problems
☐ Fire setting
☐ Food concerns
☐ Food restriction
☐ Gender identity issues
☐ Grief/loss issues
☐ Hallucinations
☐ Health Concerns
☐ Homicidal thoughts
☐ Hostility
☐ Hyperactive/Impulsive
☐ Illegal drug abuse
☐ Impulsive spending
☐ Increased Appetite
☐ Increased/Decreased Appetite
☐ Insomnia
☐ Irritability
☐ Laxative misuse/abuse
☐ Legal problems
☐ Mania
☐ Marital/significant other problems
☐ Medical problems
☐ Mood swings
☐ NLP Techniques
☐ Obsessions/Compulsions
☐ Over sleeping
☐ Pain
☐ Panic attacks
☐ Paranoia
☐ Parent-child conflict
☐ Peer relationship conflict
☐ Phobias
☐ Post-trauma symptoms
☐ Prescription drug abuse
☐ Racing thoughts
☐ Relationship problems
☐ SAD
☐ School problems
☐ Self-induced vomiting
☐ Self-mutilation
☐ Sexual compulsivity
☐ Sexual Problems
☐ Sleep Disturbances
☐ Social isolation
☐ Suicidal thoughts
☐ Tearfulness
☐ Weight Loss/Gain (significant)
☐ Work problem
☐ Other:

Functional Impairments:

☐ Daily Living (e.g., making appointments, handling money, making everyday decisions)
☐ Family Interactions/Involvement
☐ Fitness/Recreational/Leisure Activities
☐ Household (e.g., shopping, cooking, laundry, other chores)
☐ Marriage/Intimate Relationships
☐ Other
☐ Physical Health
☐ School (e.g., academic performance, completing assignments, attendance)
☐ Self-Care (e.g., hygiene, grooming, eating right)
☐ Social Interactions/Involvement
☐ Work (e.g., completing tasks, performance level, finding/keeping a job)

Environmental Problems:

☐ Competency/Guardianship
☐ Economic Problems
☐ Educational Problems
☐ Housing Problems
☐ Occupational Problems
☐ Problems Related to Interaction with the Legal System/Crime
☐ Problems Related to the Social Environment
☐ Problems with Access to Health Care Services
☐ Problems with Primary Support Group ADHD
☐ Other:

Psychiatric History

Have you previously accessed outpatient therapy?

☐ Yes ☐ No

If yes, please list date & provider name:

Name: ____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: ____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: ____ Date: ___ / ___ /____ to ___ / ___ / ____

Have you previously accessed inpatient therapy?

☐ Yes ☐ No

If yes, please list date & facility name:

Name: ____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: ____ Date: ___ / ___ /____ to ___ / ___ / ____

Name: ____ Date: ___ / ___ /____ to ___ / ___ / ____

Please indicate if you experienced or have been diagnosed with the following:

☐ Alcoholism
☐ Alzheimer's
☐ Anger Management
☐ Anorexia/Bulimia
☐ Antisocial Features
☐ Anxiety
☐ Borderline Features/ Personality Disorder
☐ Conduct Disorder/Problems
☐ Dementia
☐ Depression - Bipolar
☐ Depression
☐ Dissociative Symptoms
☐ Drug Addiction
☐ Learning Disorder
☐ Mood Disorder
☐ OCD
☐ Panic
☐ Phobias
☐ Psychosis
☐ Schizophrenia
☐ PTSD/Trauma
☐ Substance Abuse/Addiction
☐ Suicide/Self-Harming
☐ Other (specify below)

Please indicate if any family members have experienced or been diagnosed with the following:

☐ Alcoholism
☐ Alzheimer's
☐ Anger Management
☐ Anorexia/Bulimia
☐ Antisocial Features
☐ Anxiety
☐ Borderline Features/ Personality Disorder
☐ Conduct Disorder/Problems
☐ Dementia
☐ Depression - Bipolar
☐ Depression
☐ Dissociative Symptoms
☐ Drug Addiction
☐ Learning Disorder
☐ Mood Disorder
☐ OCD
☐ Panic
☐ Phobias
☐ Psychosis
☐ Schizophrenia
☐ PTSD/Trauma
☐ Substance Abuse/Addiction
☐ Suicide/Self-Harming
☐ Other (specify below)

Developmental & Educational History

Did any of the following problems occur during your mother's pregnancy with you?

☐ Emotional stress
☐ Alcohol use
☐ Drug use
☐ Cigarette use
☐ Other (please describe)

Birth/Infancy History:

☐ Normal delivery
☐ Difficult delivery
☐ Feeding problems
☐ Cesarean delivery
☐ Premature birth
☐ Sleep problem
☐ Admission to NICU
☐ Complications

Please indicate if you experienced any of the following developmental delays:

☐ Delayed Speech
☐ Delayed Walking
☐ Dev. Coordination Problem
☐ Soiling Self
☐ Bedwetting
☐ Feeding Problems
☐ Fine motor
☐ Gross motor
☐ Reactive Attachment
☐ Separation Anxiety
☐ Stuttering
☐ Toileting Difficulties
☐ Underweight
☐ Other

Please indicate if you experienced any of the following problems with educational functioning:

☐ Authority conflicts
☐ Disorder of Written Expression
☐ Dyslexia
☐ Expressive Language Disorder
☐ Illiteracy
☐ Learning Disability
☐ Learning Disorder(s)
☐ Mathematics Disorder
☐ Mixed Expressive/Receptive Language Disorder
☐ Poor Grades
☐ Reading Disorder
☐ Receptive Language Disorder
☐ School Changes (frequent)
☐ School Expulsions
☐ School Suspensions
☐ Special Education
☐ Other

Please indicate if you experienced any of the following (currently or history of):

☐ Alcohol abuse
☐ Animal cruelty
☐ Assaults others
☐ Bizarre behavior
☐ Breaks things
☐ Chronic lying
☐ Disobedient
☐ Distrustful
☐ Drug use
☐ Easily distracted
☐ Extreme worrier
☐ Fire-setting
☐ Frequently daydreams
☐ Frequently tearful
☐ Hostile/angry mood
☐ Hyperactive
☐ Immature
☐ Impulsive
☐ Indecisive
☐ Lack of attachment
☐ Not trustworthy
☐ Often Sad
☐ Poor Concentration
☐ Repeats words of others
☐ Self-injurious threats
☐ Self-injury
☐ Stealing
☐ Violent temper
☐ Other:

Adolescent Clients: Please describe your relationship with teachers and any other developmental information you feel is important:

Personal & Family History

Race/Ethnicity (optional): ____________________ Religion (optional): ___________________

Current housing situation: ____

Would you describe the home situation as:

☐ Warm and supportive ☐ Disorganized ☐ Stressful but caring
☐ Typical of most families ☐ Chaotic ☐ Other (please describe):

What is your current relationship status?

☐ Single ☐ Separated ☐ Other (please describe):
☐ Married ☐ Widowed
☐ Divorced ☐ In a committed relationship

Please complete the following table:

Name of Relative	Living? Yes or No	Current Age	Quality of Relationship	Living with you?
Mother:				
Father:				
Sister(s):				
Brother(s):				
Stepparent(s):				
Spouse or partner:				
Child(ren):				
Other significant relationships:				

Medical History

Primary care physician: _________________________________ Phone #: _______________

Date of last doctor appointment: ___ / ___ / _____

Do you feel your/your child's current physical health is:

☐ Good ☐ Fair ☐ Poor

Please describe any current chronic or serious health problems:

Please describe any serious hospitalizations or accidents:

Please list all current medications, including the dosage and reason:

Medication	Dosage	Reason

Do you currently use or previously used recreational drugs?

☐ Yes ☐ No

If yes, please complete all that apply:

Substance	Currently use?	Frequency	Amount
Alcohol			
Amphetamines			
Barbiturates			
Caffeine			
Cocaine			
Crack Cocaine			
Hallucinogens			
Inhalants			
Marijuana			
Nicotine/cigarettes			
PCP			
Prescription			
Other:			