CLIENT INTAKE ASSESSMENT

PERSONAL INFO

Full Name _____ Birthdate _____

Address _____

Cell Phone _____ Other Phone _____

Email _____

INTRO QUESTIONS

QUESTION		COMMENTS
Do you have any current diagnoses (prescribed or assumed)	Y N	
Have you ever been hospitalized?	Y N	
Have you had any previous counseling/psychotherapy?	Y N	
Please describe the type and duration.		
Are you currently in therapy?	Y N	
Do you feel comfortable with us contacting your therapist? If YES, please continue in this section	Y N	
Please share the name and phone number of the provider.		

☐	*and please sign our release of information form.

PERSONAL MEDICAL HISTORY

	CONDITION	COMMENTS
✓ Check all that apply; when asked to indicate on a scale of 1-10, 1 is least and 10 is most		
☐	Infections / Viruses / High Fever	
☐	Viral Illness	
☐	Chronic Pain (1-10: ____)	
☐	Chronic Ear Infections	
☐	Visual Condition	
☐	Lupus	
☐	Metabolic Disorder	
☐	Chemical Sensitivities	
☐	Thyroid Issues	
☐	Allergies	
☐	Tinnitus	
☐	Irritable Bowel Syndrome	
☐	Balance Problems	
☐	Incontinence	
☐	Swallowing Problems	
☐	Liver Condition	
☐	Stroke	
☐	Heart Attack	
☐	Pulmonary Condition	
☐	Endocrine Condition	
☐	Gastrointestinal Condition	
☐	Vascular Condition	
☐	Polio	
☐	HIV	
☐	Menopausal	

☐	PMS (point in cycle: _____)	
☐	Other (type: _____)	
☐	Other (type: _____)	

EXPOSURE TO TOXIC AGENTS

Please note exposure to any toxic agents (e.g., significant exposure to heavy metals, insecticides, carbon monoxide, solvents, drug overdoses, chemotherapy or radiation, etc.):

_____

_____

Describe any odd/unusual symptoms related to this exposure:

_____

_____

PERINATAL/BIRTH HISTORY

Length of labor: _____	Birth weight: _____	Adopted? Y N At age: _____

BIRTH CIRCUMSTANCE			COMMENTS
✓ Check all that apply			
☐	Premature/late delivery		
☐	Prenatal stress or injury		
☐	Birth trauma (ex: fetal distress, forceps, breech, induced)		
☐	Anesthesia		
☐	Anoxia		
☐	Medical problems after birth		
	While pregnant, did your mother:		
	☐	Smoke cigarettes?	
	☐	Use alcohol or drugs?	
	☐	Experience physical abuse?	
		Other details you feel are relevant?	

GROWTH AND DEVELOPMENT

	CIRCUMSTANCE	COMMENTS
✓ Check all that apply		
☐	Motor coordination issues	
☐	Emotional development issues	
☐	Development delay	
☐	Handedness	
☐	Language/speech/writing problems	
☐	Reading problems	
☐	Math problems	

SCHOOL	High School GPA:	College GPA:
Easy/favorite subjects:		
Hard/boring subjects:		
Which was easier to learn: Spatial Skills or Sequential Skills		

	CIRCUMSTANCE	COMMENTS
✓ Check all that apply; when asked to indicate on a scale of 1-10, 1 is least and 10 is most		
☐	Below/above grade level?	
☐	Special classes	
☐	Learning disability	
☐	Difficulty completing assignments	
☐	Behavior/discipline problems	
☐	Concentration problems (1-10: ____)	
☐	Disorganized (1-10: ____)	
☐	Forgetful (1-10: ____)	
☐	Impulsive (1-10: ____)	
☐	Hyperactive (1-10: ____)	
☐	ADD (# of criteria met_____)	
☐	ADHD (# of criteria met_____)	

NEUROLOGICAL

CIRCUMSTANCE		COMMENTS
✓ Check all that apply; when asked to indicate on a scale of 1-10, 1 is least and 10 is most		
☐	Skull/Head Surgeries/Deformities	
☐	Head Injury (blows to the head, concussions, or "seeing stars")	Total number: _____
☐	Loss of Consciousness	
☐	Neurological Disease	
☐	Memory Difficulties (1-10: ____)	
☐	Headaches or Migraines (1-10: ____)	
☐	Problems Concentrating	
☐	Seizures	
☐	Confusion	
☐	Restless Leg	
☐	Apnea or Daytime Drowsiness	
☐	Fatigue (1-10: ____)	
☐	Electroconvulsive Therapy	
☐	Incoordination	
☐	Tics/Twitches, Tremor, or Parkinson's	
☐	Weakness	
☐	Accident prone	
☐	Sensory Impairments	
☐	Lyme	
☐	Fibromyalgia	
☐	Sensitivity to Light & Sound	
☐	Anosmia (inability to smell)	
☐	Oversensitive Smell	
☐	Other (type: _____)	
☐	Other (type: _____)	

☐	Number of times you have received anesthetics: _____

ATTENTION & ORGANIZATION

CIRCUMSTANCE		COMMENTS
✓ Check all that apply		
☐	Attention Span Problem	
☐	Distractibility	
☐	Impulsivity	
☐	Difficulty with Staying Organized	

MENTAL / BEHAVIOR / EMOTIONS

CIRCUMSTANCE		COMMENTS
✓ Check all that apply; when asked to indicate on a scale of 1-10, 1 is least and 10 is most		
☐	Depression (1-10: ____)	
☐	Suicide Attempts	
☐	Mood Swings (1-10: ____)	Please specify if with or without a history of bipolar diagnosis:
☐	Anxiety (1-10: ____)	
☐	Panic Attacks	
☐	Phobias	
☐	Paranoia	
☐	Bruxism	
☐	Obsessive Rumination / Worry (1-10: ____)	
☐	OCD	
☐	Eating Disorders	
☐	Risk-Taking Behaviors	
☐	Addictions	Please specify if substance, gambling, sexual, or other:
☐	Delusions, Hallucinations, or Thought Disorder	

PHYSICAL TRAMAS

CIRCUMSTANCE		COMMENTS
✓ Check all that apply		
☐	Accidents	
☐	Coma	
☐	High Fever	
☐	Serious Illness	
☐	Surgery	
☐	CNS Infection	
☐	Drug Overdose/Poisoning	

PSYCHOLOGICAL TRAUMA / STRESSES / LIFE CHANGES

Please describe any psychological trauma you have experienced:

CIRCUMSTANCE		COMMENTS
✓ Check all that apply		
☐	Death in Family	
☐	Divorce/Remarriage	
☐	Move	
☐	School Change	
☐	Job Change	
☐	Illness	
Y N	Abuse (emotional, physical or sexual)	

OTHER AREAS OF HEALTH

EXCERCISE	Do you exercise regularly? Y N
Type:	How often:
SLEEP	Usual amount of sleep each night:

Any sleep issues (past or present)?

OTHER AREAS OF HEALTH (CONTINUED)

NUTRITION	Do you eat: ☐ Fish ☐ Red Meat ☐ chicken or turkey	Use artificial sweeteners/diet drinks? Y N
I feel better when I eat/drink:		
Do you experience any cravings? Y N Please explain:		
Any nutrition issues (past or present)?		
SUBSTANCE USE/ABUSE	Please describe your substance use/abuse history:	

FAMILY MEDICAL HISTORY

Please describe any significant family history of illness, medical condition, or mental disorder:		
CIRCUMSTANCE		WHO / COMMENTS
✓ Check all that apply and indicate who within your family within the comments		
☐	Depression or Suicide	
☐	Bipolar/Manic Depression	
☐	Epilepsy	
☐	Migraines	
☐	Alcoholism or Drug Abuse	
☐	Tourette's (Motor or Vocal Tics)	
☐	ADD/ADHD	
☐	Learning Disability	
☐	Speech Problems	

☐	Autism or Asperger's	
☐	Schizophrenia	
☐	OCD	
☐	PMS	
☐	Chronic Fatigue	
☐	Fibromyalgia	
☐	Thyroid Problems	
☐	Dementia	

FINAL COMMENTS

Are there any other areas of health which have been bothering you?

_____

_____

_____

Describe your idea of wellness:

_____

_____

_____

How will you know when you are done with therapy and training?

_____

_____

_____

_____