Sea Change, LLC

INTAKE ASSESSMENT

Client Name: _____ Date: _____
Age: _____ DOB: _____
Relationship Status (circle one). Married Separated Divorced Partner Widowed Single
Spouse/partner's first name: _____
How many years in relationship: _____
Children (names and ages): _____
_____
Education (High School, College): _____
Current Occupation: _____
Person to alert in the event of medical emergency: _____
Relationship to you: _____
Family Doctor: _____

Please describe any significant current or past medical problems:

_____
_____
_____

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

_____
_____
_____

Have you had previous psychological care or counseling? ☐Yes ☐No
If yes, please give the name of the clinician(s), the months you were seen (for example, Nov. '06–Feb. '07), and the nature of the difficulty at the time.

_____
_____
_____
_____

Have you ever been hospitalized for a psychological difficulty? ☐Yes ☐No

If yes, please give the dates and the nature of the difficulty at the time:

_____
_____
_____
_____

Completed by: Date:

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like.

Therapy can be a powerful force for change. In order for it to be most effective, it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

1. _____
2. _____
3. _____

Additional Stressors: _____

Your Strengths: _____

Previous attempts at problem solution: _____

Client/Family History of Substance Abuse/Mental Illness/Eating Disorders: _____

Current or previous trauma/family violence: _____

Completed by: **Date:**

List of Symptoms:

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Completed by: Date:

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Family:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Completed by: Date:

Mood:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Completed by: Date:

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol?_____

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:_____

Other:

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed. _____

_____

_____

Completed by: Date:

RISK ASSESSMENT

1. Current suicidal ideation: _____
   _____
   _____

   i. Current plan:

   ii. Current means:

2. Past History of suicidal ideation or attempts (when and how)_____
   _____
   _____
   _____

3. Current homicidal ideation: _____
   _____
   _____

   i. Current plan:

   ii. Current means:

4. Action recommended and/or taken: _____
   _____
   _____

Mental Status Exam

Appearance:	Grooming:	____Normal ____Disheveled ____Unusual
	Hygiene:	____Normal ____Body Odor ____Bad Breath
Motor Activity:		____Relaxed ___Restless ____Pacing ____Sedate ____Threatening ___Catatonic ___Posturing ____Mannerisms ___Psychomotor retardation ___Psychomotor agitation ___tremors ___Tics
Attitude:		____Cooperative ____Oppositional/Resistant ____Defensive ____Other: _____
Speech:		____Normal ____Pressured ___ Slow ___ Dysarthric ____Apraxic
Expressive Language:		____Normal _____Circumstantial _____Anomia ____Paraphrasia ____Clanging ____Echolalia ____Incoherent _____Neologisms

Completed by: Date:

Receptive Language: ____Normal ____Abnormal: _____

Mood: ____Normal _____Euphoric _____Elevated ____Depressed
____Angry _____Irritable _____Anxious

Affect: ____Normal ____Reactive ____labile ____ depressed
____anxious ____Tearful ____Blunted _____Flat
____Constricted

Orientation: ____normal ____abnormal:_____
Estimated IQ: _____Above Average _____Average _____ Below Average
Attention: _____Normal ____Inattentive ____Distracted _____Hypervigilant
Concentration: _____Normal _____Brief
Memory: _____Normal ____abnormal
Thought Process: ____Goal Directed and Logical ____Circumstantial
____Confabulation ____Flight of Ideas _____Ideas of Reference
____Grandiosity _____Paranoia _____Magical Thinking
____Obsessions _____Preservation _____Delusions

Thought Content: _____Suicidal Ideation: Thoughts, Intent, Plan
_____Homicidal Ideation: Thoughts, Intent, Plan

Sleep: _____Insomnia, Hypersomnia, frequently waking up
_____# hours of sleep per night

Hallucinations: _____None ____auditory _____visual ____Olfactory
Judgement: _____Good ____Fair ____Poor _____TBA
Insight: _____Good ____Fair ____Poor _____TBA
Impulse Control: _____Good ____Fair ____Poor _____TBA

Preliminary Diagnosis:

_____

_____

Recommendations for treatment:

_____

_____

_____
Kimberly A. Popkey, MA, LPC, CEDS, SEP

Completed by: Date: