Client Name_____

Arrow Counseling Services, LLC

ADULT AND ADOLESCENT (14 YRS OLD AND OLDER) INTAKE ASSESSMENT

Please complete this form before your first appointment. *All information contained herein is confidential in accordance with the attached policies and procedures and in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment and care possible.*

Name: _____ Age:_____

Address: _____ Date of Birth _____

_____ Gender: Male Female (Circle One)

How would you like us to contact you? (Please circle response)

Home:	yes or no	Phone:	Cell phone:	yes or no	Phone:
Work:	yes or no	Phone:	Other:		
Email:	yes or no	Email address:			

Name of person completing form: _____

Relationship to person receiving services: _____

In case of an emergency during a therapy session if I become unable to communicate or need medical or non-medical assistance, the person I authorize you to contact is located on the Intake Form.

Name: _____

Contact Phone: _____

Current Presenting Issue/Concern

1. Presenting Problem/ Chief Complaint (include impact on social, work, and/or academic functioning):

Client Name_____

Please indicate the severity of the symptoms you are experiencing:

Symptoms Experienced in the last **two (2) weeks**	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	Symptoms Experienced in the last **two (2) weeks**	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Aggression toward others				Lack of pleasure in doing things			
Anger Outbursts				Lack of Trust			
Anxiety				Legal Issues			
Attention-Deficit				Lonely			
Avoidant behaviors				Lying			
Can't be alone				Manipulative			
Binging				Memory loss			
Compulsive Behaviors				Mood swings			
Crying				Nightmares			
Controlled by others				Obsessive Thoughts			
Controlling others				Oppositional Defiant			
Disruptive Behavior				Out of body experiences			
Depression				Overeating			
Drug or Alcohol Use				Panic Attacks			
Enuresis/ Encopresis				Physical fights			
Fear				Physical pain			
Fear of crowds				Poor concentration			
Fear of leaving home				Poor Self Esteem			
Feeling Empty				Poor sleep			
Feeling worthless				Pornography			
Financial Problems				Post-Partum Depression			
Fire setting				Purging Food			
Flashbacks				Racing Heart			
Gambling				Racing Thoughts			
Grandiose Thoughts of self				Relationship Issues			
Hallucinations				Restricting Food			
Headaches				Risk Taking			
Hearing Voices				Sad			
Hoarding				Self-Harm Behaviors			
Homicidal Ideation				Sexual Dysfunction			
Hurts animals				Sexual Identity Confusion			
Hyperactivity				Sexually Promiscuous			
Impulse Control				Sleep Disturbance			
Indecisiveness				Spiritual Confusion			
Infidelity				Suicidal Ideation			
Irritable				Suspicious of others			
Isolated				Uncontrolled spending			
Lack of eating				Unwanted memories			
Lack of pleasure in doing things				Verbally abusive			
Lack of Trust							
Legal Issues							
Lonely							

2. Please indicate the severity that your problems and/or symptoms are affecting the following?

In the last **two (2) weeks**	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	In the last **two (2) weeks**	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Handling everyday tasks				Sexual activity			
Work/School				Relationships			
Recreational activities				Legal matters			
Self esteem				Hygiene			
Housing				Health			
Finances							

Please circle the number that best indicates how motivated you are for change

1 2 3 4 5 6 7 8 9 10

Minimally motivated Moderately motivated Extremely motivated

Current and Past Psychiatric Treatment

1. Are you currently or have you ever been in psychiatric treatment of any type?

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

2. Did you have a positive experience in your previous treatment? Yes No

3. Were you compliant with previous treatment? Yes No

4. Any **history** or **current** thoughts/plans/acts/ideation or intention of suicide? Yes No

If yes, circle all that apply: Passive Thoughts Single Attempt Multiple Attempts

If yes, explain: _____

_____

5. Any **history** or **current** thoughts/plans/acts/ideation or intention of homicide? Yes No

If yes, circle all that apply: Passive Thoughts Violence Towards Another

If yes, explain: _____

_____

6. Do you feel that you are **currently** (within the past 6 months) at risk for Dangerous Behaviors?

Yes No

If yes, identify any situation that increases risk for dangerous behaviors and fill out **Crisis Safety Plan form** at the end of this packet:

_____

_____

Client Name_____

MEDICAL INFORMATION

Medication: Please list all medications including prescribed, over the counter and homeopathic.

Name	Dosage	Frequency	Prescribed By	Reason for prescription

Please list all Health Care Providers: **Name** May we contact them to coordinate care? **Phone number**

Primary Care Physician			Yes	No
Psychiatrist			Yes	No
Caseworker			Yes	No
Case Manager			Yes	No
Other _____			Yes	No

Medical History: *Circle all that apply:*

Breathing Problems	Diabetes	High Blood Pressure	High Cholesterol
Heart Problems	Impaired Ability to Walk	Infectious Disease	Impaired Hearing
Thyroid	Impaired Vision	Liver Problems	MR/DD/LD
Obesity	Seizure Disorder	Ulcer	GI Problems

Other:_____

5. Any concerns regarding medical history:
_____
_____

6. Any allergies or special precautions? Yes No Unknown
If yes, specify: _____
_____

7. Height _____ Weight_____

SUBSTANCE USE

1. Please check all that apply:

Drugs, Alcohol, or Substances:

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								

Tranquilizers								

DEPENDENCE

2. Do you find yourself using more of your chosen substance? Yes No
3. Do you suffer from withdrawal when you try to quit? Yes No
4. Do you use to excess? Yes No

DOES (OR HAS) YOUR USE:

5. Interfere with your daily life? Yes No
6. Place you in hazardous situations? Yes No
7. Cause you legal problems? Yes No
8. Cause you interpersonal conflict? Yes No

OTHER ADDICTIONS

7. Any history of gambling? Yes No
8. Any history of sexual acting out, pornography, sex crimes, legal charges, harmful behaviors, etc.? Yes No
9. Any history of overeating, restricting, and/or purging food? Yes No
10. Any history of addiction related to internet, video games, social media, shopping, etc? Yes No

TRAUMATIC EVENTS

1. Have you ever witnessed Domestic Violence? Yes No
If yes, please explain: _____
_____

2. Any current or past experience of trauma (any negative experience that you cannot forget): Yes No

If yes, *circle all that apply*:

Emotional Abuse Neglect Physical Abuse
Sexual Abuse Verbal Abuse Domestic Violence
Developmental/Caregiver Trauma Witnessed Abuse Other:_____

If yes, describe the above or <u>any other traumatic experience</u>: _____
_____
_____
_____
_____

3. Have you received services for past trauma? Yes No N/A
If yes, please describe:
_____
_____

STRENGTHS/CHALLENGES/ BARRIERS TO TREATMENT

List any leisure activities or hobbies:
_____
_____

Who makes up your current support system?
_____
_____

How do you cope with life events and daily stress?
_____
_____

List any **barriers or challenges** to treatment and to change?
_____

Client Name_____

FAMILY

1. Please list the following people in your life:

Relationship	Name	Birthdate	Describe him/her (e.g. angry, outgoing, supportive, controlling)
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

2. Describe your childhood and adolescence (atmosphere, location, significant events).
Circle all that apply:

Parents Divorced	Parents Separated	Parents Remarried
No Involvement of Biological Parents	Parent(s) Deceased	Raised by Grandparents
Raised by Others	Good/Happy Home	Strict Home
Religious Home	Unfair Home	Abusive Home
Absent Family	Multiple Homes	Other

Explain:_____
_____
_____

3. Are significant issues from childhood impacting current presenting problem? Yes No
If yes, *Circle all that apply:*

Trust Issues with Current Relationships	Intrusive Memories
Difficulty with Activities of Daily Living	Ongoing Tense Relationships with Family
Difficulty with Academic/School Functioning	Loss of Family with Residual Feelings

Explain: _____
_____
_____

4. How well did your parents/guardians get along with each other? □ Great □ Good □ Fair □ Poor □ Terrible

5. How well did you get along with your parents/guardians? □ Great □ Good □ Fair □ Poor □ Terrible

6. Have any **family members** had a history of Mental Illness: Yes No
If yes, please describe below:

Family Mental Health Problems	Who?	Please Describe
Hyperactivity		
Sexually Abused		
Depression		
Manic Depression		
Suicide		
Anxiety		
Panic Attacks		
Obsessive-Compulsive		
Anger/Abusive		
Schizophrenia		
Eating Disorder		
Alcohol Abuse		
Drug Abuse		
Mental Retardation		

7. Family History of Medical Problems? Yes No

Family Medical Health Problems	Who?	Please Describe
Heart Problems		
Cancer		
Diabetes		
Thyroid		

EDUCATIONAL AND DEVELOPMENTAL INFORMATION

1. Do you have any problems of an academic nature? Yes No
If yes, describe issues: _____
_____

2. Highest level of education you have completed:_____

3. Describe how you did in school. *Circle all that apply*:

Good/Decent Grades	Fair/Poor Grades	Retained
Learning Disability	No Behavior Issues	Some Behavior Issues
Frequent Behavior Issues	Suspended/Expelled	Dropped out

4. Do you have a history of any developmental delays or issues? Yes No
If yes, specify: _____
_____

5. Do you have qualities that could be academic strengths? Yes No
If yes, specify: _____
_____

Client Name_____

Special Needs:	Living Situation:	Social Support System:
○ Require Sign language Interpreter ○ Require Primary Language interpreter (language)_____ ○ Require wheel chair accessible room ○ Other _____	○ housing adequate ○ homeless ○ housing overcrowded ○ dependent on others for housing ○ housing dangerous/deteriorating ○ living companions dysfunctional	○ supportive network o few friends o substance-use-based friends o no friends o distance from family of origin

Employment:	Legal History:	Military History:
o employed and satisfied o employed but dissatisfied o unemployed o coworker conflicts o supervisor conflicts o unstable work history o disabled:	○ no legal problems o now on parole/probation o arrest(s) not substance-related o arrest(s) substance related o court ordered this treatment o jail/prison _____ time(s) total time served:_____	○ never in military o served in military – no incident o served in military – with incident o currently serving in military o honorable discharge o other type of discharge:

Relationship History:	Cultural/Spiritual/Recreational History:
	○ Cultural Identity (ethnicity, religion): _____ ○ Describe any cultural issues that contribute to current problem(s): _____ ○ Currently active in community/recreational activities? o Yes o No ○ Formerly active in community/recreational activities? o Yes o No ○ Currently engage in hobbies? o Yes o No ○ Currently participate in spiritual activities? o Yes o No

Financial Situation:	Relationship History and Current Family:
○ no current financial problems o large indebtedness o poverty or below-poverty income o impulsive spending o relationship conflicts over finances	o married o divorced o single o widowed o in a relationship ○ children living at home ○ children living elsewhere

Additional Information you feel would be helpful for your therapist:

_____

_____

_____

_____

_____

_____

I have answered truthfully and to the best of my ability regarding all of the information contained in this Adult Intake Assessment.

Patient Signature_____ Date _____

Therapist Signature _____ Date _____

Client Name_____

Crisis and Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____ 2. _____

3. _____ 4. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity): See Coping Technique Handout

1. _____ 2. _____

3. _____ 4. _____

Step 3: People whom I can ask for help and social settings that provide distraction:

1. Name_____ Phone_____

2. Name_____ Phone_____

3. Place_____

4. Place_____

Step 4: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____

2. Clinician Name_____ Phone_____

3. Arrow Counseling After Hour Emergency phone number: (717) 758-8075

4. Crisis Intervention Services Phone number: 717-851-5320

5. Hospital Address: **York Hospital, 1001 S. George St, York Pa 17401; Memorial Hospital, 325 S. Belmont St, York, PA 17405: Hanover Hospital , 300 Highland Ave, Hanover, PA 17331**

6. Emergency Services: **Dial 911 on phone**

Step 5: Making the environment safe:

1.
_____

2.
_____

Step 6: Medications I can take during a crisis (Take as prescribed by medical doctor)

Name	Dosage	Frequency	Prescribed By

I will not hurt myself or anyone else, but rather will abide by this plan and seek help during a crisis.

Patient Signature_____ Date _____

Therapist Signature _____ Date _____