CLIENT INFORMATION

Client SSN: _____

Legal Name _____ Today's Date _____

Address_____

_____ City
State Zip Code

Home Phone_____ Work Phone _____ Cell Phone _____
Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

E-Mail Address_____ Birthdate_____ Age_____

Emergency Contact _____
Name and phone number

Occupation_____Employer/School_____

Number of years (or highest level of) education _____

Gender _____ Relationship (or Couple) Status _____

Race/Ethnicity_____

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*
_____

If client is a minor, name/address/phone of custodial parent, if different from name above _____
_____

Gross annual family income $_____ per year Number dependent on this income _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)* Clarify if client is a minor from two households *(Include any different last names.)*

Name	Age	Gender	Relationship	Living with you?
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No

Religion _____
Place of worship_____

Is it important for you to have spirituality included in your therapy? ☐ Yes ☐ No

PLEASE CONTINUE ON PAGE 2

Chart #_____
For Confidential Use Only

Chief Complaint:	
History of Present illness:	
Past Psychiatric/Psychological History:	
Past Medical History:	
Past Surgical History:	
Allergies:	

Current Medication List

Medication	Dose	Frequency	Prescriber	Reason

Past Medication List

Medication	Dose	Frequency	Prescriber	Reason

PLEASE CONTINUE ON PAGE 3

Drug/Alcohol Assessment

Which substances are currently used	Method of use (oral, inhalation, intranasal, or injection)	Amount of Use	Frequency of use (times/month)	Time period of use	Which substances have been used in the past
__Alcohol					__Alcohol
__Caffeine					__Caffeine
__Nicotine					__Nicotine
__Opiates					__Opiates
__Marijuana					__Marijuana
__Cocaine/Crack					__Cocaine/Crack
__Methamphetamines					__Methamphetamines
__Inhalants					__Inhalants
__Stimulants					__Stimulants
__Hallucinogens					__Hallucinogens
__ Other:					__ Other:

Suicidal/Homicidal Ideation

Is there a suicide risk?	___No ___ Yes	___ Patient refused to answer
Previous Attempt? __No __ Yes	Current Plan? __ No __ Yes	Means? __ No __ Yes
Intent? __ No __ Yes	Lethality of Plan? __ No __ Yes	
Do you have thoughts of harming others? __ No __ Yes	Current Plan? __ No __ Yes	Means to carry out plan? __ No __ Yes
Intent? __ No __ Yes	Lethality of Plan? __ No __ Yes	
High risk behaviors?	___ None ___ Cutting	___ Anorexia/Bulimia
	___ Head banging	___ Other: _____

Abuse Assessment

In the past year have you been hit, kicked, or physically hurt by another person? __ No __ Yes Explain:
Are you in a relationship with someone who threatens or physically harms you? __ No __ Yes Explain:
Have you ever been forced to have sexual contact that you were not comfortable with? __ No __ Yes Explain:
Have you ever been abused? __No __ Yes If yes, describe by whom, when and how.

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Family/Social History

Born/Raised	

Siblings	_____ # of brothers	_____ # of sisters
What is your birth order?		_____ of _____ children
Who primarily raised you?		
Describe marriages or significant relationships		
Number of Children: _____		
Current living situation:		
Military history/type of discharge:		
Support/social network:		
Significant life events:		

Family History of Mental Illness

Relative	Mental Illness

Employment

What is your current employment status?
Do you like your job?
Will this job likely be done on a long-term basis?
Do you get along with your co-workers?
Do you perform well at your job?
Have you ever been fired from the job? Yes No If yes, explain
How many jobs have you had in the last five years?

Education

Highest grade completed:
Schools attended:
Discipline problems:

Current Legal Status

____ No legal problems	____ Parole
____ Probation	____ Charges Pending
____ Previous jail	____ Has a guardian

CONTINUE ON PAGE 5

Developmental History

Describe the childhood: ____ Traumatic ____ Painful ____ Uneventful
Describe the childhood in relation to personality, school, friends, and hobbies:
Describe any traumatic experiences in the childhood: (List the age when they occurred)

Spiritual Assessment

Religious background:
Do you currently attend any religious services? __ No __ Yes If yes, where?

Cultural Assessment

List any important issues that have affected your ethnic/cultural background

Coping Skills

Describe how you cope with stressful situations:

Is your coping methods: ___ adaptive ___ maladaptive

Interests and Abilities

What hobbies does the patient have?
What is the patient good at?
What gives the patient pleasure?

Mental Health Status Assessment

(Describe any deviation from normal under each category)

Arousal/Orientation					
___ Alert	___ Sleepy	___ Attentive	___ Unresponsive		
___ Oriented to Person	___ Oriented to Place	___ Oriented to Time	___ Confused		
___ Other:					
Appearance					
___ Well groomed	___ Good eye contact	___ Poor eye contact	___ Disheveled		
___ Bizarre	___ Poor Hygiene	___ Inappropriate dress			
___ Other:					
Behavior/Motor Activity					
___ Normal	___ Restless	___ Agitated	___ Lethargic		
___ Abnormal facial expressions	___ Tremors	___ Tics			
___ Other:					
Mood/Affect					
___ Normal	___ Depressed	___ Flat	___ Euphoric	___ Anxious	___ Irritable
___ Liable	___ Indifferent	___ Careless	___ Inability to sense emotions	___ Lack of sympathy	
___ Other:					
Speech					
___ Normal	___ Nonverbal	___ Slurred	___ Soft	___ Loud	

___ Pressured	___ Limited	___ Incoherent	___ Halting	___ Rapid
___ Other:				
Attitude				
___ Cooperative	___ Uncooperative	___ Guarded	___ Suspicious	___ Hostile
___ Other:				
Thought Process				
___ Intact	___ Flight of ideas	___ Tangential	___ Concrete	___ Loose
___ Circumstantial	___ Neologisms	___ Racing	___ Word Salad	___ Unable to think abstractly
___ Other:				

Thought Content		
___ Normal	___ Phobia	___ Hypochondriasis
___ Delusions	___ Obsessive	___ Preoccupations
___ Other:		

Delusions				
___ None	___ Religious	___ Persecutory	___ Grandiose	___ Somatic
___ Ideas of reference	___ Thought broadcasting	___ Thought insertion		
___ Other:				

Hallucinations	
___ None	___ Auditory hallucinations
___ Visual hallucinations	___ Command hallucinations
___ Other:	
Describe:	

Impulse Control				
___ Normal	___ Partial	___ Limited	___ Poor	___ None
___ Frequently participates in activities without planning or thinking about them				

Judgment	
___ **Normal**	___ **Poor**

Insight

____ Normal ____ Poor
Is the patient able to meet their basic needs (e.g., food, shelter, medical):
___ Yes ___ No
If no, describe:

Functional Ability
(Check the area of concern)

___ None	___ Daily living activities	___ Work	___ Finances
___ School	___ Family relationships	___ Social relationships	___ Safety
___ Legal	___ Cognitive functioning	___ Physical health	___ Housing
___ Housing	___ School	___ Impulse Control	___ Social skills

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ADDITIONAL QUESTIONS

Are you a returning client? ___ Yes ___ No How did you learn about EMNS? _____

Did you come because of legal or DHS issues? _____ Name of person referring _____

Relationship to you _____

FOR THERAPIST USE

Therapist _____ **Office** _____ **DX Code** _____ **Fee** _____ **Date** _____

Method of payment ____ Ins* ____ EMNS Grant Funds ____ EAP ____ 3rd Party Non-insurance Guarantor (i.e., church) ____ Self-Pay

- **Insurance Information form must be completed double-signed by client, stapled to photocopy of medical card, included with intake paperwork.**

File: ____ Individual ____ Couple ____ Family (Number of family members) ____ Group

If Couple or Family: check one ____ Primary client (patient for insurance purposes: contact for scheduling) ____ Additional client(s)

Counselor Signature:	**Date/Time:**
Supervisor Signature:	**Date/Time:**