Barbara C. Stellard, MA, LPC
Licensed Professional Counselor
318 Houston Avenue, Suite 202
Muskegon, MI 49441

Initial Intake Assessment

CLIENT INFO

Name: _____ Date of Birth: ___/___/___

Address: _____

City, State, Zip: _____ Gender: M___ F___

Contact Info: Home: _____Work: _____Cell: _____ Email: _____

May we call you at home? Yes No May we leave a message at home? Yes No
May we call you on your cell? Yes No May we leave a message on cell? Yes No
May we contact you via email? Yes No May we leave a message via email? Yes No
(Please Note: email communication is not considered to be a confidential means of communication)

Marital Status: Never Married Separated Domestic Partnership Divorced Married Widowed

Children/Ages, if any: _____

EMERGENCY CONTACT INFO

Emergency Contact: Name: _____ Phone: _____

Relationship: _____

HEALTH & MEDICAL INFO

Primary Care Physician: _____ Phone No: _____

Psychiatrist: _____ Phone No: _____

Please list any medical problems: _____

_____

Please list any current medications & dosages: _____

_____

_____

How is your overall health?: _____

Previous Counseling Services (if any): No_____ Yes_____ (if yes, please explain)

_____

_____

_____

REASON for VISIT

What brings you to counseling? _____

_____

_____

_____

How distressing is this issue? _____

_____

SYMPTOM ASSESSMENT - please give as accurate account as you can; if you have any questions or concerns, I invite you to discuss them with me. PLEASE CIRCLE YOUR RESPONSE & THEN NOTE FOR HOW LONG.

I AM EXPERIENCING…

1.	Frequent worry or tension	Yes	No	How Long_____
2.	Fear of many things	Yes	No	How Long_____
3.	Discomfort in social situations	Yes	No	How Long_____
4.	Feelings of guilt	Yes	No	How Long_____
5.	Phobias: unusual fears about specific things	Yes	No	How Long_____
6.	Panic Attacks: sweating, trembling, shortness of breath, etc)	Yes	No	How Long_____
7.	Recurring, distressing thoughts about a trauma	Yes	No	How Long_____
8.	Flashbacks as if reliving the traumatic event	Yes	No	How Long_____
9.	Avoiding people/places associated with trauma	Yes	No	How Long_____
10.	Nightmares	Yes	No	How Long_____

I AM FEELIING…

1.	Decreased interest in pleasurable activities	Yes	No	How Long_____
2.	Social isolation; loneliness	Yes	No	How Long_____
3.	Suicidal Thoughts	Yes	No	How Long_____
4.	Bereavement or Feelings of Loss	Yes	No	How Long_____
5.	Changes in sleep (too much or not enough)	Yes	No	How Long_____
6.	Normal, daily tasks require more effort	Yes	No	How Long_____
7.	Sad, hopeless about future	Yes	No	How Long_____
8.	Excessive feelings of guilt	Yes	No	How Long_____
9.	Low self-esteem	Yes	No	How Long_____

I NOTICE…

1.	I am angry, irritable, hostile	Yes	No	How Long_____
2.	I feel euphoric, energized & highly optimistic	Yes	No	How Long_____
3.	I have racing thoughts	Yes	No	How Long_____
4.	I need less sleep than usual	Yes	No	How Long_____
5.	I am more talkative than usual	Yes	No	How Long_____
6.	My moods fluctuate; go up and down	Yes	No	How Long_____

I HAVE…

1. Memory problems or trouble concentrating Yes No How Long_____
2. Trouble explaining myself to others Yes No How Long_____
3. Problems understanding what others tell me Yes No How Long_____
4. Intrusive or strange thoughts Yes No How Long_____
5. Obsessive Thoughts Yes No How Long_____
6. Been hearing voices Yes No How Long_____
7. Problems with my speech Yes No How Long_____

I HAVE…

1. Risk taking behaviors Yes No How Long_____
2. Compulsive or repetitive behaviors Yes No How Long_____
3. Been acting without concern for consequences Yes No How Long_____
4. Been physically harming myself Yes No How Long_____
5. Been violent toward other(s) Yes No How Long_____

I USE THE FOLLOWING…

1. Alcohol Yes No How Long_____
2. Nicotine (cigarettes or chewing tobacco) Yes No How Long_____
3. Marijuana Yes No How Long_____
4. Cocaine Yes No How Long_____
5. Opiates Yes No How Long_____
6. Sedatives Yes No How Long_____
7. Hallucinogens Yes No How Long_____
8. Stimulants Yes No How Long_____
9. Methamphetamines Yes No How Long_____

MY EATING INVOLVES…

1. Restriction of food consumption Yes No How Long_____
2. Bingeing and Purging Yes No How Long_____
3. Binge eating Yes No How Long_____
4. Weight loss or gain Yes No How Long_____

I HAVE…

1. Concern about my sexual function Yes No How Long_____
2. Discomfort engaging in sexual activity Yes No How Long_____
3. Questions about my sexual orientation Yes No How Long_____

EMPLOYMENT…

1. I am employed Yes No How Long_____
2. I am looking for work Yes No How Long_____
3. I am disabled Yes No How Long_____

PERSONAL & FAMILY HISTORY…

1. Have you or a close relative ever been hospitalized for a psychiatric illness? Yes No How Long_____
2. Does anyone in your family have a mental illness? Yes No How Long_____
3. Has anyone in your family ever attempted or committed suicide? Yes No How Long_____
4. Does anyone in your family have a substance abuse problem? Yes No How Long_____
5. Have your ever been arrested? Yes No How Long_____

If you answered yes to any of the above in this section, please briefly explain: _____

_____

_____

_____

_____

_____

1. How well you are doing on your job:

___n/a ___can't function ___serious problems ___moderate problem ___mild problems ___no problems

2. How well you are doing in your marital/significant other relationship:

___n/a ___can't function ___serious problems ___moderate problem ___mild problems ___no problems

3. How well you are doing in your family relationships:

___ n/a ___can't function ___serious problems ___moderate problem ___mild problems ___no problems

4. How well you are doing in relationships with people outside your family:

___n/a ___can't function ___serious problems ___moderate problem ___mild problems ___no problems

5. Please rate your current physical health:

___n/a ___can't function ___serious problems ___moderate problem ___mild problems ___no problems

6. Please rate your general happiness and well being:

___n/a ___can't function ___serious problems ___moderate problem ___mild problems ___no problems

What significant life changes or stressful events have you experienced recently*:*_____
_____
_____
_____
_____

Do you consider yourself to be spiritual or religious? ___Yes ___No; if yes, please describe your faith/belief:
_____
_____

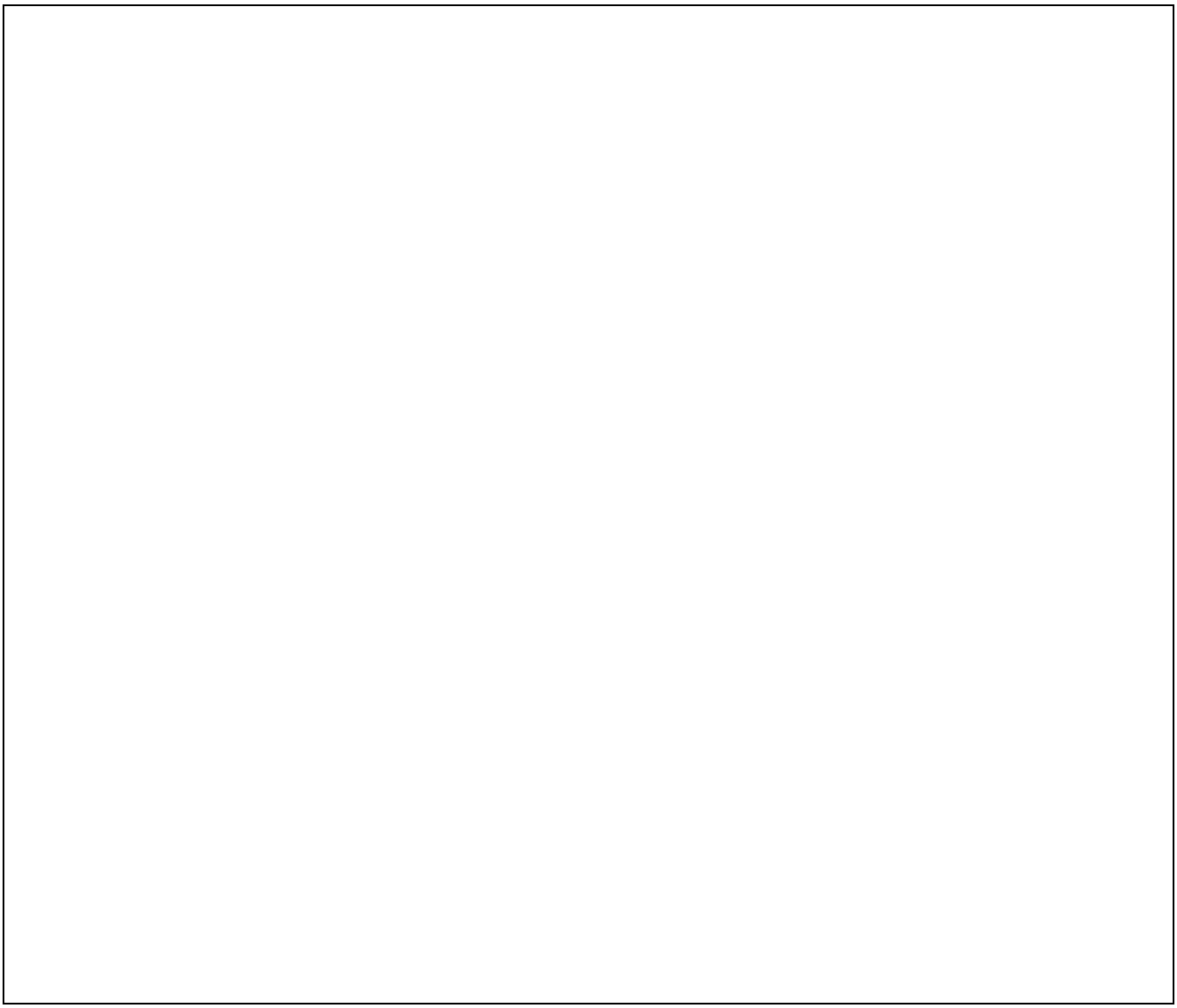
What are your strengths/abilities*:*_____
_____
_____
_____

What do you want to accomplish from your counseling? _____
_____
_____
_____

PLEASE NOTE*: to avoid identity theft, I will make a copy of your driver's license and/or ID card & insurance card(s)*

Signed: _____ Date:_____

Clinical Assessment



DX: _____

DX: _____