Caleb Brooks

Psychotherapy Evaluation Intake Form

1. Client Contact Information

Client Name___________________________________ Preferred Name ________________
Last First MI

Address____

Best contact phone number: ________________Email address: __________________________

Referred by: ____

2. Date of Birth __ __ / __ __ / __ __ __ __
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3. Age ____ Years

4. Race/Ethnicity (Check one <u>or</u> more):

☐ American Indian/ Alaskan Native ☐Asian ☐ AfricanAmerican ☐ Hispanic ☐ Caucasian ☐ Other________

5. Current marital status (Check one):

☐ Single,never married ☐ Married,living together ☐ Separated ☐ Widowed ☐ Cohabiting with partner ☐ Divorced

☐ Married,not living together ☐ Other ____

6. If you are married or cohabitating with partner, how long has this been?

7. Total number of marriages ____ **How many children do you have?** ____

8. Spouse's/Partner's Name:

9. Who else lives with you?

10. How many years of formal education have you completed? ____ Years

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11. Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4 year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.
☐ Junior college degree or technical school diploma ☐ J.D./LL.B. ☐ Ph.D ☐ Other__________

12. What best describes your current employment status? (Check one from each category a, b, & c)

a. Employment Status

☐ Unemployed, not looking for employment
☐ Unemployed, looking for employment
☐ Full-time employed ☐ Part-time employed
☐ Retired ☐ Self-employed
☐ On welfare ☐ Social security disability

b. Student Status

☐ Part-time
☐ Full-time
☐ Not a student

c. Volunteer Status

☐ Volunteer Part-time
☐ Volunteer Full-time
☐ No Volunteer Work

13. What is your occupation?

14. Current Residence

☐ Own my house/ condo ☐ Retirement Complex/Senior Housing ☐ RENTING ☐ Apartment /Condominium

15. What is your spouse's occupation?

16. Have you ever seen a therapist or psychiatrist before? If yes, describe treatment

17. Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

18. Has anyone in your family ever been treated for depression, anxiety, schizophrenia, suicide attempts, alcohol or drug dependence, or other mental health issues? (Please describe)

19. Medical History: Please share any serious medical issues you are currently dealing with or have encountered in the past (i.e. chronic pain, sleep apnea, gastrointestinal problems, eating disorders, head injuries, genital problems, etc.) that may be relevant to your issue or treatment.

20. Please List all current medications below that you are currently taking.

21. Regarding alcohol and drug use, what is your level of usage (frequency and amount)?

22. Is there anything else in particular you feel that the therapist should know about you as you begin therapy?

Emergency contact: ________________________________Phone #______________________________________