**Intake Assessment**

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**Reasons for seeking care**

What brings you to therapy?

**Are you seeking a medication evaluation?**

Yes

No

What goals do you have for this treatment?

**Current symptoms**

**What symptoms have you had now or within the past 30 days? Select all that apply**

Angry

Anxious

Cannot be in crowds

Cannot concentrate

Cannot sleep

Compulsive behavior

Depressed

Disturbing thoughts

Eating too much or too little

Fearful

Feeling worthless

Food/eating changes

Grief/sadness

Guilt

Hearing things

Hopeless

Identity concerns

Impulsive

Lack of confidence

Lack of interest

Nervous

Obsessive thinking

Overwhelmed

Panic attacks

People out to get me

Poor memory

Prefer being alone

Recurring nightmares

Relationship problems

Restless

Seeing things

Self-harm

Sleep changes

Sleep too little

Sleep too much

Stress

Substance use

Suspicious

Talk too fast

Tired/fatigued

Additional symptoms

**Are you a survivor of trauma?**

Are you a survivor of trauma?YesNoN/ANot sure

**Substance use**

Do you regularly use any form of tobacco?

**Would you or someone you know say you have had a problem with…**

**…alcohol use?**

Yes

No

**…pills or illegal drugs?**

Yes

No

**…other addictions, like gambling, pornography or shopping?**

Yes

No

If yes, please describe:

**Is there a history of addiction in your family?**

Yes

No

**Personal, family and relationships**

How are your relationships with your family members?

Have there been any problems with your family in the past or currently, such as abuse, conflicts, stress or loss?

How are your relationships with your extended support circle, such as with friends, classmates or colleagues?

Have there been any problems with your support circle in the past?

What is your relationship status?

Have you ever had problems in your current or past relationships?

Anything else about your family and social relationships you want to add?

**Education**

**What is the highest level of education you have completed?**

What is the highest level of education you have completed?

No education

K - 5th6th - 8th9th - 12thGED

/High school

degreeCollege degree

Master's degreeAdvanced degree

Would you describe your schooling experience as positive overall?

**Are you currently in school or a training program?**

Yes

No

**Work**

What do you do for work?

**How long do you usually stay in a job before moving from something else?**

Weeks

Months

About a year

Longer than 1 year

**What's your military status?**

I have never served in the military

Active

Retired

Reserves

Other

**Medical history**

**Are you allergic to any food or medications?**

Yes

No

If yes, please describe:

What current and past medications have you taken?

Has your current physical health prevented you from participating in activities or impacted your mental health?

**Do you currently have a primary care physician?**

Yes

No

If yes, include the following information:

First name

Last name

Contact information

Ideally phone number

What past and current medical problems have you had, including any relevant surgical procedures?

**Mental health history**

**Have you seen mental health professionals previously?**

Yes

No

If yes, include the following information:

Name of provider

Time period

Reason for terminating or changing

Current APRN/Psychiatrist, if applicable

**Have you previously received a diagnosis from a mental health provider?**

Yes

No

If yes, what was the diagnosis?

**Are you currently attending or have you ever been to a self-help group?**

Yes

No

If yes, describe the group:

What current and past psychiatric medications have you taken?

Did you experience side effects or adverse reactions?

Have you ever misused or overused a prescription medication?

Have you ever been admitted to a psychiatric hospital? Why?

**Have you ever attended an Intensive Outpatient Program or Partial Hospital Program?**

Yes

No

**Other**

Is there anything else you’d like to share?

If you are currently having any thoughts of self harm or suicide its important that you seek immediate crisis intervention or suicide prevention services. For immediate assistance, dial 911 or go to your local emergency room. You can also reach out to the following resources:

* 1-800-SUICIDE - 24-hour suicide prevention line that can be called from anywhere in the U.S. https://988lifeline.org/
* If you’re uncomfortable making a phone call, you can Text HOME to 741741 to connect with a Crisis Counselor

Please note: Headway is not a crisis hotline. This screening tool will be reviewed and scored by a trained clinical staff member but may not be immediately reviewed at time of submission. It is important that if you are in imminent risk of suicide that you contact the resources provided.

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