Your Journey to Finding Peace, LLC

1585 Old Norcross Road, Suite 201B, Lawrenceville, GA 30046
(678)392-0727

INTAKE ASSESSMENT FORM

Demographic Information

Date: ________________ Name: ____ Gender: ☐ F ☐ M

Address: ____ City: ___________________ Zip Code: __________________

Phone (Home/Cell): _____________________________________ Phone (Work): _________________________________

Date of Birth: __________________ Age: ______________ Marital Status:______________________________________

Guardian Name (if minor): _____________________________ Relationship (to minor): ____________________________

Family Members (who live in your household)			
Name	Age	Gender	Relationship

Emergency Contact Information:

Name of Emergency Contact Name: ____

Phone 1: _____________________ Phone 2: ____________________ Relationship to Patient: ____________________

Current Employer: ____ Work Phone #:_____________________________

Occupation/Job title: ____ Length of time with this employer: ___________

Insurance Information:

Primary Insurance: _________________________________ Insurance policy holder: ______________________________

Insurance policy number: _______________________________ Policy holder SS#: ______________________________

I hearby assign to Your Journey To Finding Peace LLC, all benefits payable under the terms of my insurance policy listed above. I realize that I am responsible for any expenses incurred in the collection of outstanding balances not covered by insurance attorney. Payment is due at the time of service.

____ ____

Client Name (printed Therapist Name (printed)

____ ____

Client/Guardian Signature Date Therapist Signature Date

Current Providers:

Primary Medical Doctor: ____ Phone: ______________________

Psychiatrist or other behavioral Health Specialists: _________________________ Phone:_______________________

Presenting Problem, including, onset, duration: ____

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____

Precipitating Event (why treatment now): ____

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____

Target Symptoms: ___________________________________ Frequency/Duration: ___________________________

Symptom #1: _______________________________________ Symptom #2: _________________________________

Symptom #3: _______________________________________ Symptom #4: _________________________________

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage/Relationship:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Family:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Job/school performance:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Financial Situation:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Physical health:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Anxiety level/nerves:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Mood:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Eating habits:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Sleeping habits:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Sexual functioning:

☐ No effect ☐ Little effect ☐ Some effect ☐ Much effect ☐ Significant effect Not applicable

Risk Assessment:

Suicidal Ideation – select and describe in comments section

☐ None ☐ Thoughts ☐ Frequency ☐ Plan with Intent

☐ Attempt (most recent) ______________________________

Comments: ______________________________

____

____

____

____

Homicidal Ideation – select all that apply and describe in comments section

☐ None ☐ Thoughts only ☐ Frequency of thoughts ______________________________

☐ Plan ☐ Intent Means Attempt

Comments: ______________________________

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Select one:

☐ Abused as a child	☐ Agoraphobia	☐ Alcohol use Alcohol abuse	☐ Anger
☐ Anxiety	☐ Appetite	☐ Being a parent	☐ Bowel trouble
☐ Career choices	☐ Children	☐ Concentration Confidence	☐ Depression
☐ Divorce	☐ Drug/use abuse	☐ Eating problem	☐ Education
☐ Energy (hi/how)	☐ Extreme fatigue	☐ Fears	☐ Fetishes
☐ Finances	☐ Friends	☐ Guilt	☐ Headaches
☐ Health issues	☐ Insomnia	☐ Inferiority feelings	☐ Loneliness
☐ Memory	☐ My thoughts	☐ Making	☐ Marriage
☐ Nervousness	☐ Nightmares	☐ Obsessive thinking	☐ Overweight
☐ Painful thoughts	☐ Panic attacks	☐ Others: ______________________________	

Risk Factors

Have you ever experience abuse in your life (please select all that apply)

Domestic Violence/intimate partner:

☐ Physical Abuse ☐ Child Abuse ☐ Sexual Abuse ☐ Emotional Abuse

History of multiple behavioral diagnosis (please check all that apply)

☐ Eating Disorder ☐ Other (describe) ______________________________

Medical/Behavioral Health History

Have you ever had a Mental Health Diagnosis? ☐ Yes ☐ No

(Depression, Bipolar, etc) (if yes, please describe)

____
____
____
____
____
____

Past Psychiatric History (Mental Health and Chemical Dependency)

* Have you ever received In-Patient Psychiatric Treatment? ☐ Yes ☐ No Psychiatric Hospitalizations:

When and Where?

____
____
____
____
____

Prior Outpatient Therapy

Name of therapist: ___________________________ Dates of treatment: ___________________

Are you currently receiving any type of Mental Health Treatment? ☐ Yes ☐ No

Medications:

Are you currently taking any medication (prescribed or over the counter) (s)? ☐ Yes ☐ No

Name	Dosage	Frequency

Family Mental Health or Chemical Dependency History:

Does anyone in your family have a Mental Health or Chemical Dependency history?

____
____
____
____
____

Allergies (adverse reactions to medications/food/etc.)

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____

____

____

____

Support Systems:

Whom do you turn to for support? ___________________________________ School/Work Life: ___________________

Legal History:

Do you have any current or past legal issues?

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____

____

____

____

Substance Abuse History (complete for all patient age 12 and over) select that all applies:

Frequency ___________________________ First Use _______________________ Last Use______________________

☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Opioids/ Narcotics ☐ Amphetamines

☐ Cocaine ☐ Hallucinogens ☐ Others: ____

Developmental History:

☐ Milestones ☐ met ☐ early ☐ late ☐ normal ____

Client's Signature: ____ Date: _________________________

Therapist Signature: ____ Date: _________________________