Dr. Greta Zuck
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Adult Intake Evaluation

Please complete this confidential intake evaluation completely.

Today's date:_____

Demographic Information

Full name: _____

Gender _____ Race/ethnicity_____ Date of birth / age:_____

Complete address: _____

_____

Phone numbers: Home: _____ Work: _____Cell: _____

Email address: _____

Emergency contact person and phone number(s): _____

If applicable please state who referred you to this office: _____

Presenting Issues

Please briefly state why you are seeking professional counseling services at this time and what you hope to achieve: _____

_____

_____

_____

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_____

Symptom checklist: Please choose relevant symptoms with

(**F**) -- frequent; (**S**) -- sometimes; (**R**) -- rarely. Leave blank those that you do not experience at all.

Depressed mood		Feeling disoriented or dizzy	
Depressed mood with mixed periods of elevated and expansive mood ("highs and lows")		Physiological symptoms (heart palpitations, sweating, shortness of breath, trembling, nausea)	
Diminished interest in previously enjoyed activities		Excessive worrying without being able to stop	
Feelings of loneliness		Thoughts of suicide or wishing to be dead	
Significant weight loss		Panic or "anxiety attacks"	
Significant weight gain		Obsessions (not being able to get thoughts out of you mind)	
Insomnia (can't get to sleep)		Physically sick often	
Hypersomnia (over sleep)		Compulsions (feeling compelled to behave in a certain way without being able to stop)	
Memory impairment		Muscle tension and rigidity	
Difficulty maintaining sleep through night		Fear of losing control	
Nightmares		Hallucinations	
Fatigue or loss of energy		Phobias (fears of certain things or events)	
Diminished ability to concentrate and focus		Substance abuse or addiction	
Suspiciousness and paranoia		Problems related to sexual issues	
Avoiding people		Aggression, violent toward others	

Other:

_____

_____

Please state how long you have been having the above noted symptoms and give examples of how these symptoms interfere with your ability to function: _____

_____

_____

_____

_____

_____

_____

List your greatest strengths:_____

_____

_____

List your greatest weaknesses:_____

_____

_____

List your main social difficulties:_____

_____

_____

List your main love and sex difficulties:_____

_____

_____

List your main difficulties with work and/or school:_____

_____

_____

List your main difficulties at home:_____

_____

_____

Please list any additional information that would be helpful for me to best understand you:_____

_____

_____

_____

_____

Personal Information

Please state marital status details and the number of children you have: _____

_____

_____

_____

Please state all members who reside with you and their relationship to you:_____

_____

Please note your highest level of education completed: _____

Please list your occupation: _____

If you are employed, please state your thoughts and feelings about your job: _____

_____

_____

_____

If you have a particular religious, cultural, or spiritual affiliation and you would like your beliefs incorporated into the counseling process, please state this here: _____

_____

_____

_____

Please disclose if you have suffered any legal difficulties or penalties, other than minor traffic violations, as an adult *(this information will be held in strict confidence)*:_____

_____

_____

Please list hobbies or extracurricular interests you have: _____

_____

_____

Medical and Psychological History

Please state your primary care physician: _____

If applicable, please state all current medical illnesses along with current medication taken and dosage:_____

_____

_____

If applicable, please state any past medical illnesses along with medication and dosage:_____

_____

_____

Please state if you have been involved in counseling/psychotherapy previously and, if so, state the reason and outcome of services received:_____

_____

_____

_____

Please note any medical or mental health illness in your biological family (e.g., depression, anxiety, substance abuse/addiction, genetic disorders, neurological disorders, emotional/physical/sexual abuse, antisocial/criminal behavior, etc: _____

_____

_____

_____

_____

_____

Childhood Information

Which of the following best describes the family you grew up in?

Warm and accepting Average Hostile and fighting

1 2 3 4 5 6 7 8 9

Which of the following best describes the way in which your family raised you?

Allowed me to be independent Average Attempted to control me

1 2 3 4 5 6 7 8 9

Please state what type of family you grew up in (e.g., a traditional family with both biological parents, a divorced family with one parent, a blended family with step-parents and siblings, an adoptive family, etc.): _____

_____

_____

_____

Briefly describe your mother (or mother figure) and your relationship with her: _____

_____

_____

_____

Briefly describe your father (or father figure) and your relationship with him: _____

_____

_____

_____

Briefly describe your relationships with siblings, if applicable: _____

_____

_____

_____

Please note any traumatic, unusual or difficult experiences you experienced growing up as a child:_____

_____

_____

_____

Thank you for completing this intake form.

Therapist fills out section below

Mental status exam

_____

_____

_____

_____

_____

Clinical Impressions / Recommendations

_____

_____

_____

_____ _____

Greta Zuck, PhD, LCMHCS, NCC, RPT-S Date