Clack Associates, LLC
Angela R. Clack, PsyD, LPC
License#37PC00323700

Adult Screening Form/Intake Assessment

Today's Date:

Client Name: ______________________________ DOB: _______________ Age: _________
Who referred you to us? ____
Address: ___________________________ City _______________________Zip____________
Home Phone: _______________ Work: ________ Cell: _______________________
Highest Level of Education/Last grade completed : _________________________________
List additional training or certification obtained after high school or college: _______________________________________

____

List All Family Members and Others Who Are Currently Living In Your Home:

Name	Age	DOB	Relationship	Occupation

Employment/Primary Source of Income: ____
Other Sources of Income: ____
Current Salary Range: ____

Martial Status: Never Married ____ Engaged ___ Separated ___ Married___
Divorced ___ Widowed ___

Spouse/Partner Name: ______________________ Age: ________
If Married, Divorced: How many years? ________
If you are divorced or separated, please describe your past relationship with spouse: _______________________________

____

If you are currently married, please describe your relationship with your spouse: __________________________________
____

Briefly described your reason(s) for seeking help at this time: ____
____
____
How long has this been a problem?____
____

Adult Screening Form/Intake Assessment

What other stressors are in your life that complicate alleviation of distress? ____
____
____

What have you already tried to cope with your current situation? ____
____
____

With everything that you are going through right now have you thought about doing anything drastic or perhaps violent to yourself or anyone else? ____
Have you ever had any suicidal thoughts, feelings, or attempted suicide in the past?____
Do you have any suicidal or homicidal thoughts or feelings now? ___________________________

Name of client's primary care physician: __________________________ _____________

Address: ______________________________________Phone: _____________________

When were you last examined by a physician? __________________________________

Are you on medication? (Include vitamins and over the counter drugs) Yes __ No __

Please list any medications you are currently prescribed?

Drug Name:_________________ Dose: _______________ Started: ______Reason: _____________
Drug Name:_________________ Dose: _______________ Started: ______Reason: _____________
Drug Name:_________________ Dose: _______________ Started: ______Reason: _____________

Does client have any known allergies? Yes __ No __
If so, to what: _________________________________

Is there any history of medical problems in client's family? Yes __ No __

If yes, please describe: ____
____

List any major health problems for which you are currently receiving treatment? ___________________________________
____
____

Have you or any member of your family received psychiatric and/or psychological help or counseling of any kind in the past? (including substance abuse treatment) ____
____
____

If yes, who received treatment and the reason? ____
____
____

Who provided these services and where? ____
____
____

Was it helpful? Why or why not?____
Are you currently in treatment/counseling with a behavioral healthcare provider? ___________________________________
____

Do you have a history of drug/alcohol abuse? YES NO

Adult Screening Form/Intake Assessment

If YES (drug/alcohol), what was the drug(s) of choice?____
____
____

Do you have any firearms, weapons, dangerous chemicals in your dwelling? Or access to?______________________
____

List any other important issues (i.e. legal suit, Workmen's Compensation, etc.):______________________________
____

Legal Status:

i. Have you ever been arrested for any illegal activities? Yes __ No __

If yes, explain: ____

ii. When? ___________________ Are there outstanding charges against you? ____

Are you currently on probation? Yes __ No __

If so, when did the probation start? ____________ When is it ending? ________

Activities and Social Group Participation:

Please list all leisure, structured and cultural activities you are currently participating in: ____________________
____

Current Symptoms/Problems: (rate severity and duration for each)

Key: Severity Rating: 1=Mild 2=Moderate 3=Severe

Duration Rating: 1=less than 1 month 2=1-6 months 3=7-11 months 4=More than 1 year

	Severity	Duration		Severity	Duration
1. Anxiety	_______	_______	15. Bizarre Ideation	_______	_______
2. Panic Attacks	_______	_______	16. Bizarre Behavior	_______	_______
3. Phobia	_______	_______	17. Paranoid Ideation	_______	_______
4. Obsessive Compulsive	___	_______	18. Gender Issues	_______	_______
5. Somatization	_______	_______	19. Eating Disorders	_______	_______
6. Depression	_______	_______	20. Poor Judgement	_______	_______
7. Impaired Memory	_____	_______	21. Lack of Support System	_____	_______
8. Poor Self Care Skills	____	_______	22. Poor Interpersonal Skills	____	_______
9. Loss of Interest	_______	_______	23. Conduct Problems	_______	_______
10. Loss Energy	_______	_______	24.School Problems	_______	_______
11. Sexual Dysfunction	_____	_______	25. Family Problems	_______	_______
12. Sleep Disturbance	_____	_______	26. Indep. Living Problems	_____	_______
13. Appetite Disturbance	___	_______	27. Unusual Body Movements	__	_______
14. Weight Change	_______	_______	28. Other:	______________	_______

Adult Screening Form/Intake Assessment

Please describe symptoms/problems in detail:

How will you know if treatment has been successful?____
____
____
____

Third Party/Insurance Carrier

Insurance Carriers	Policy Holder	Group and Policy #

Portion of Counseling Services Covered by Insurance: _________________________
Deductible: _______________ Co Payment: ___________________________________
Insurance Carrier's Phone # for Mental Health/Substance Abuse Benefits: ________________________
____

*Please **initia**l each of the following items to indicate your agreement:*

_______ Your insurance company/managed health care group might **require** that clinical information be provided to them in order for you to receive these services. If payment or pre-certification of benefits is denied by your carrier, you will be responsible for payment.
_______ All fees are payable at the time of visit(s), unless special arrangements have been made. Your insurance/mental health group might require pre-authorization for your treatment visits. The group might require pre-authorization for your treatment visits.
_______ Appointments cancelled without adequate notification (24 hours notice) or broken without justifiable reason will be billed at the co pay rate. This fee is not reimbursable by your policy coverage.

_________________ ___________________________________
Date Your Full Signature

Adult Screening Form/Intake Assessment

Adult Assessment Intake Form CA02

Summary of Clinical Impressions/Diagnosis

Client Name: D.O.B.

Type of Diagnosis: ⬭ Admission ⬭ Discharge ⬭ Update

Axis I: Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention (ICD-9 CM)

___ ___ ___. ___ ___ ____

___ ___ ___. ___ ___ ____

___ ___ ___. ___ ___ ____

Substance Abuse/Dependency:

Does a substance abuse/dependency issue exist? ☐ YES ☐ NO ☐ Unknown/Not Reported

If yes, which substance disorder is the primary substance abuse diagnosis? ○ a ○ b ○ c ○ d

Axis II: Personality Disorders; Mental Retardation

___ ___ ___. ___ ____ ____

___ ___ ___. ___ ____ ____

General Medical Condition: Summary by Client Report or Medical Record Documentation