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Client Admission Summary

Evaluation Date _____ Referred By_____

Client Name_____ Date of Birth_____

Address_____

Phone
(H)_____(W)_____(C)_____

Messages okay? H_____W_____C_____ E-mail: _____

Identifying Information: Age_____ Marital Status_____ SS#: _____

Psychiatrist/Primary Therapist:_____ **Phone**:_____

Socio-Medical-Family Background:
Name and ages of family members or people living in the house with you:
_____
_____
_____
_____
_____

Please Check All That Apply
Family history of: ____Alcohol/ substance abuse _____Abuse/Neglect (sexual / physical /other_____)
_____Domestic Violence _____Mental illness (depression / anxiety/ other_____)
_____Parental incarceration _____Attachment or bonding problems _____Other:_____

Currently experienced by you: _____Alcohol/other substance use _____ Sexual/Physical abuse
_____Domestic violence _____ Mental illness (depression / anxiety/other_____)
_____History of head trauma _____Problems related to pregnancy/labor/delivery
_____ Medical conditions:_____ _____Family concerns:_____
_____ Restricting food intake _____ Binge eating _____ Purging/intentionally regurgitating food
_____Other:_____

Please include additional information on the items you checked:
_____
_____
_____
_____
_____

Religious/Spiritual Practices:
_____
_____

Prior therapy: Prior outpatient or inpatient therapy? Y / N If yes, please describe:
Inpatient: _____
Outpatient_____

Any prior diagnostic or psychological evaluations: Y / N If yes, please list evaluators and dates_____
_____

Any history of suicidal or homicidal thoughts, plans or actions: Y / N If yes, please elaborate_____
_____
_____

If there is a history of suicidal thoughts, plans or actions, are you willing to make a Safety Plan? Y / N

Legal: Past or current court involvement: Y / N If yes, please describe _____
_____

Educational: Highest grade completed or current grade: _____ Name of School _____
Behavioral and academic concerns at school: ____ aggressive; ____ destructive; ____ talks out; ____ poor attention span; ____ distractibility; ____ trouble focusing; ___ poor academic performance; ___ poor social skills; ___ disciplinary problems; ___ oppositional-defiant; _____other _____

Interpersonal Relationships
Parents: (Describe past and current relationships with parents/caregivers/guardians)
_____
_____
_____
_____
_____

Siblings: (Describe past and current relationships with siblings/step-siblings)
_____
_____
_____
_____
_____

Other family members: (Describe past and current relationships with other family members)
_____
_____
_____
_____

Peers: (Describe past and current relationships with friends and neighbors)
_____
_____
_____
_____

School/Work: (Describe past and current relationships with teachers, bosses, employees and coworkers)

_____
_____
_____
_____
_____

Medical: Any current or prior major medical problems or hospitalizations? Y / N If yes, please list current and past medical conditions, dates and locations of hospitalizations:

_____
_____
_____

Primary Physician_____ Phone Number _____

Date of last medical evaluation_____ Do you want therapist to consult with physician? Y / N

If applicable, any complications with pregnancy, labor or delivery? Y / N If yes, please describe: _____
_____

Please describe any personal history of substance use (alcohol, recreational drugs, non-prescription drugs)

_____
_____

Current substance use? Y / N If yes, please describe type of substance, the frequency and amount used

_____
_____

Any known or suspected history of traumatic brain injury: Y / N If yes, please list dates and circumstances

_____
_____

Medication history: Any past medication use? Y / N If yes, please list medications and dates prescribed

_____
_____

Please list **all** current medications (including vitamins, supplements, and over the counter medications taken regularly), dosage and dates_____

_____
_____
_____

Please describe any other significant medical / developmental experiences from infancy to present)

_____
_____
_____
_____
_____
_____
_____

Treatment Information and Goals:
Please list your current diagnosis, if applicable: _____

Please identify current symptoms, concerns or problem areas that you would like to address in therapy:

1. _____
2. _____
3. _____
4. _____
5. _____

Please feel free to add any additional information about these current symptoms, concerns or problem areas:
_____
_____
_____
_____
_____

What triggered the onset of your current symptoms, concerns, or problem areas:
_____
_____
_____

Do you have any concerns about therapy or the therapeutic process? _____
_____
_____
_____
_____
_____

Please list your strengths and resources: _____
_____
_____
_____
_____

What are your goals or expectations of therapy? Please, be as specific as possible
_____
_____
_____
_____
_____
_____
_____

Are you able to commit to regular attendance? Y / N If no please elaborate
_____