Intake Form for Heidi Savell, LCSW, CADC I

Name: _____ DOB: _____

Pronouns used (example: she/her; they/them):_____

Relationship structure (example: monogamous, polyamorous, etc.)_____

Relationship status: _____ Highest education completed: _____

Names and ages of children, if any:
_____

Employment status/occupation:
_____

Who do you live with?
_____

What brings you in today?
_____
_____
_____
_____

Describe your previous counseling or mental health treatment experiences:
_____
_____
_____

Current physical or mental health diagnoses & medications:
_____
_____
_____

What do you think about your diagnosis & the medication you use?
_____
_____
_____

Past diagnoses & medication experience:
_____
_____
_____

Please describe if/how you have been affected by trauma (abuse, domestic violence, accidents, injuries, death, neglect, etc.)?
_____
_____
_____

Is there anything you feel has been an ongoing or longstanding challenge for you?

_____
_____
_____

Have you had substance abuse treatment before? When and where?

_____
_____
_____

Has anyone in your life expressed concern about your drug/alcohol use? If so, who and what was their concern?

_____
_____
_____

What are your goals for therapy?

_____
_____
_____

Is there anything else you think I should know now?

_____
_____
_____

Symptoms (within last 6 months unless otherwise noted)	***YES***	***NO***
Have you been down, depressed, or hopeless in the past month?		
Do you experience little interest or pleasure in doing things?		
Has your appetite changed (eating more or less)?		
Has your sleep been disturbed (insomnia or over-sleeping)?		
Do you feel worthless or guilty?		
Do you have sudden or unexpected bouts of anxiety or nervousness?		
Do you often feel tense, worried, or stressed?		
Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
Do you worry about a lot of different things?		
Do you avoid placed or situations because of anxiety or worry?		
Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors?		
Have you been through any significantly stressful periods in the past 6 months?		
In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse?		
Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminders of the event?		
Do you use prescription medicines or street drugs to relax, calm your nerves, or get high?		
Have you made an effort to cut down on your drinking or drug use?		
Have you been annoyed by people who criticize your drinking or drug use?		
Do you ever feel guilty about your drinking or drug use?		
Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms?		

Have you ever attempted suicide? ☐ Yes / ☐ No If yes, when?

_____

Do you have thoughts of seriously harming yourself or others now? ☐ Yes / ☐ No

Substance Use history:

Have you ever had treatment for substance-abuse? ☐ Yes / ☐ No

If yes, when and where:_____

Substance	Age at First Use	Date/Age at Last Use	Duration & Frequency of Use
Alcohol			
Marijuana			
Methamphetamines			
Amphetamines			
Cocaine			
Benzodiazepines			
Barbiturates			
Hallucinogens			
Opiates (Prescription)			
Methadone			
Heroin			
PCP (Angel Dust)			
Inhalants			
Prescription Drugs			
Other illicit Substances			
Caffeine			
Tobacco (smoking/chewing)			