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Connecticut ● Florida ● Georgia ● Iowa ●
North Carolina ● South Carolina

INITIAL INTAKE REPORT

Client Name(s):_____ **Date:**_____

Therapist's Name: _____

A. Presenting Problem:

B. General History

1. **Abuse/Neglect:**

2. **Traumas:**

3. **Medical History**

4. **Substance Dependence/Addictions:**

FAMILY, FRIENDS, RELATIONSHIPS

C. Family:

1. **Mother:**

2. **Father:**

3. **Siblings:**

4. **Other Family:**

D. Romantic Relationships:

E. Sexual Functioning/Issues:

F. Social Support:

G. Self-Care/Coping Mechanisms:

H. Diet/Exercise:

I. Spirituality/Religion:

J. Career

1. **Education:**

2. **Current Position:**

3. **Past Positions:**

K. Recommendations / Future Plans / Referral:

L. Client Strengths/Prognosis:

M. Diagnosis/Diagnoses:

MENTAL STATUS EXAM

Appearance: Neat___Disheveled___Appropriate Attire___Other_____
Physiological Signs: Restless___Tearful___Tense Posture___Agitated___Decreased Motor Activity___Relaxed___
Manner and Attitude: Accessible___Evasive___Defensive___Euphoric___Suspicious___Irritable___Guarded___
Frightened___Aggressive___Optimistic___Passive___Resentful___Other_____
Orientation: Time___Place___Person___Situation___ **Eye Contact:** Direct___Intermittent___Intense__Poor___
Verbal: Answers Appropriate___Rambling___Detailed___Circumstantial___Repetitive___Slow___Rapid___
Thought Content: Normal___Hallucinations___Delusions___Obsessions___Ruminating___Flight of Ideas___

Therapist's Signature: _____