Laura Fish MS, LMFT
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Intake and Assessment Summary

Date:

Client(s) Name	Age	Date of Birth

Address

Street City St ZIP

Phone: Email:

Employer(s):

Emergency Contact: Relationship: Phone:

Others living with the client(s):

Name	Age	Relationship

Medical Review

Physicians you are working with currently:

Approximate date of last physical exam:

List *all* current medications or supplements (attach separate list if needed):

What are the conditions for which you receive regular medical care?

Past history of accidents or surgeries:

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Are there ***currently*** and problems with:

	Yes	No
Sleeping too much		
Sleeping too little		
Weight gain		
Weight loss		
Extreme mood swings		
Excessive sadness		
Loss of pleasure in usual activities		
Excessive worry		
Repetitive thoughts		
Repetitive behaviors		
Thoughts of self-harm		
Thoughts of harm to others		
Unusual eating habits		
Police involvement		
Substance abuse		
Violent behavior toward others		

Is there ***history*** with any of the above? If so, please list:

How often do you use substances and what kind?

Please list other behaviors of concern currently:

What type of counseling or other form of support services you have sought out in the past for these, or other, concerns. Include hospitalizations or outpatient treatment:

Family History:

Does anyone in your family have a mental health diagnosis or have they received treatment? Please describe:

Is there a history of any of the following types of abuse or neglect?
_____ Physical _____ Verbal _____ Emotional _____ Sexual

Was this abuse or neglect reported? Please describe briefly:

What are your current goals for therapy? Please be specific if possible:

What strengths do you have to help you achieve these goals?