Clinical Intake Assessment

Part 1 Basic Information

Section A

Name____ Date__________________

Phone: (H) ____________________ (W)__________________ (C) __________________

SS# ________________________ DOB ______________________ Age _____________

Address ____

Email Address ____

Section B

Marital status (circle one): single married separated divorced widow life partner

Current Living Situation ____

How long have you lived here?____

Person Financially Responsible, if not self ____

Employed? Y/ N, How long?_________________Employer's Name ___________________

Position___________________________________ Hours/ week ______________________

Student ? Y/N, Course of Study_________________Hours/ week _____________________

Section C

How did you hear about me?____

Are you currently involved with the legal system? Y/N If yes, please explain_______________

____

Section D

Client Statement- Why are you seeking treatment at this time? What do you hope to achieve?

Maira Holzmann
LICENSED CLINICAL SOCIAL WORKER

Part 2 Medical and Mental Health Information

Section A

Current Care Providers

	Name with Credentials	Phone number	How long have you seen?	Frequency of visits	Most Recent Visit
Current Therapist					
Current Psychiatrist					
Current Physician					

Current Medications

Medication	Dose	Frequency	Indication	Last Dose	When Started	Prescribed by

Previous Treatment

	Treatment for what purpose?	Facility or Professional Name	Location	Start and End Dates
Inpatient or Residential				
Partial Hospitalization (PHP)				

Outpatient Therapy				
Dietary/ Nutritional Counseling				
Support groups				
Other				

Section B
Any current or **past medical issues** that impair your current functioning? If yes, please explain below:

Please list any symptoms that you are currently experiencing: depression, anxiety etc. How long have you been experiencing these symptoms?

How have you been coping with your stressors and symptoms?

Do you have a history of **suicidal thoughts or attempts**? Any current struggles? If yes, please explain below:

Do you have a history of **self-destructive behaviors**? If yes, please explain below:

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LICENSED CLINICAL SOCIAL WORKER

Part 3 Eating Disorder Information

Section A

Current Weight ___________________________ Height _______________________________

Recent changes in weight / Over what period of time ______________________________________
____

Highest non-pregnant weight__________ When _____________ Circumstances________________

____

Lowest Adult Weight ________________ When _____________ Circumstances________________

____

Level of Satisfaction with current size and shape 1 2 3 4 5
(not at all satisfied to very satisfied)

What is your ideal weight? ______________________

Percentage of the day spent with thoughts about food, body image, and/or weight concerns? ____

What methods or rituals do you use to measure or assess your body?

When and how did the eating disorder begin?

Section B

Diet- Please describe any restrictive diets that have been followed, when and for how long? Describe current eating patterns and any food rules or rituals present.

Fear or hate foods? __________________________ Won't eat ___________________________

Restricting Behavior- Describe pattern of missed meals or restricting calorie intake

Count Calories Y/ N Count Fat Grams Y/N

Binge Eating Behaviors- Please describe a typical binge: where, when, what, how often in day, how long does episode last?

Purging Behavior

	Have you ever?	How often now?	Method or type	Onset of 1st use	Most severe use	Date last used
Through vomiting	Y/N					
Through over-exercise	Y/N					
Laxatives	Y/N					
Diuretics	Y/N					

Please describe your current exercise: type, how often, time spent

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Part 4- Support System

Family Members and other supports

Relation	Name	Age	Where living?	Supportive?
Mother				
Father				
Spouse				
Sibling				
Sibling				
Sibling				
Other				
Other				
Other				

_______________________________ _______________________

Client Signature **Date**