AMMIRATI COUNSELING
Empowering Your Relationships

2211B Lakeside Drive
Bannockburn, IL 60015

1401 Branding Lane, Suite 241
Downers Grove, IL 60515

Phone: (847)217-9381 Fax (224)544-5575

Intake Assessment

(To be completed by each individual attending each session)

Client's Name _____ Date of Birth _____

Age _____ Sex: M / F Marital Status: _____

Address: _____

City/State _____ Zip _____

Referral Name _____

For Couples

Are you currently in individual therapy?

__No __Yes (If Yes) Therapist's Name _____

Precipitating Factors

In general terms, why are you seeking counseling at this time:

_____

What would you like to accomplish out of your time in therapy?

_____

Treatment History

Outpatient: __No __Yes Date(s) _____ (If Yes) Previous Therapist _____

Inpatient: __No __Yes Date(s) _____ (If Yes) Previous Therapist _____

Current or Recent General Symptoms

(Please Circle)

Appetite Change	Loss of Interest	Frequent Anger	Disturbed Sleep
Self Injurious Behavior	Lying	Despondent	Illegal Behaviors
Isolation	Hopeless	Tearful	Motivation Loss
Truancy	Sad	Feelings of Guilt	Damaging Property
Mood Swings	Physical Complaints	Bullying/Fighting	Impulsivity
School Problems	Cruel to Animals	Increased Energy	Racing Thoughts
School Anxiety	No Energy	Relationship Problems	Impaired Social Ability
Poor Judgement	Restless	Hyperactive/ADHD	School Refusal
Rebellious	Suicidal Thoughts	Homicidal Thoughts	Suicidal Attempts

Other: _____

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Current or Recent Anxiety or OCD Symptoms

(Please Circle)

Restless	Panic Attacks	Obsessions	Unable to Function
Fears	Paranoid/Suspicious	Worrying	Ruminating
Cleanliness	Orderliness	Avoiding	Hair Pulling
Skin Picking	Impulses/Tics	Counting	Reassurance Seeking
Checking	Repeating	Washing	Hoarding
Thought Spinning	Trauma Flashbacks	Other: _____	

Current or Recent Other Symptoms

Disoriented/Confused	Hallucinations	Delusions
Aggression/Hostility	Severe Paranoia	Disorganized Thoughts
Disorganized Speech	Racing Thoughts	False Beliefs
Excited Behaviors	Memory Impairment	Wandering

Other: _____

Any current or past eating disorder behaviors? _____

_____

Any current or past substance abuse behaviors? _____

_____

Current Withdrawal Symptoms: _____

_____

Current Medical Conditions and Allergies: _____

_____

_____

Current Medications

Medication name and dosage _____ Prescribing MD _____

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Relationship Status

(Please Circle)

Single Married Partnered Separated Divorced Widowed Other _____

Relationship satisfaction: _____

_____

Current Household

Please list the names, ages and relationships of the people living in your home:

Name	Age	Relationship	Comments

Current or Recent Employment

Job title or function _____ Company _____

How symptoms have interfered with employment responsibilities _____

_____

_____

Current or Recent Education

Name of school _____ Year or grade _____

How symptoms have interfered with school responsibilities _____

_____

_____

Spirituality and Faith

Do you identify with a religion or faith? Y / N If so, which religion or faith? _____

How have symptoms affected or been affected by religion or faith? _____

_____

_____

Signed _____ Date _____

Witness _____ Date _____