Thomas Bender
3500 Comanche Blvd NE, Building E, #13
Albuquerque, NM 87107
(505) 681-1140

Intake Assessment

Last	**First**	**Middle**

Client's Date of Birth / Age / Gender

DOB (mm/dd/yyyy)	**Age**	**Gender (circle one)**
		Male Female

Social Security Number	

Client Contact Information

Street Address	**City**	**State**	**Zip**

Home Phone	**Cell Phone**	**Work Phone**
( )	( )	( )

E-mail	**Primary Phone Number (circle one)**
	Home / Cell / Work / Other: _____

Insurance & Funding

(circle all that apply)	**Insurance Company**
Insurance / Cash	

Client's Member # (Insurance)	**Insurance Group #**	

Primary Holder's Name	**Is there another health benefit plan?**	**Co-Pay Per Visit &**
	Yes No	$_____

Primary Policy Holder's Employer	**Primary Policy Holder's DOB (mm/dd/yyyy)**	**Primary Policy Holder's SSN #**

Primary Providers

Psychiatrist Name	**Psychiatrist Address**	**Psychiatrist Phone**
		( )

Emergency Contacts

Name	**Relationship**	**Cell #**	**Work #**	**Home #**
Name	**Relationship**	**Cell #**	**Work #**	**Home #**

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Current Medications (Medical or Psychiatric)

Medication **Dosage** **Frequency** **Reason**

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

Allergies

1)	2)	3)

Hospitalizations

(Medical) **Date** **Reason**

(Psychiatric) **Date** **Length of Stay** **Hospital Name** **Reason**

Personal and Family History

Highest Level of Education	**Current School**
Father's Highest Level of Education	**Mother's Highest Level of Education**

Relationships

Relationship Status	**Partner's First Name**	**Number of Years Together**
	Number of Shared Children	
Are you Employed?	**What do you do for a Living?**	

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Family Information

	Name	Biological or Adoptive?	Age	Occupation	Do you have Contact?	(Circle One)
Father					Yes No	Living / Deceased
Mother					Yes No	Living / Deceased

Parents Marital Status	(Circle One)	Length of Time
	Married Divorced Separated	

	Name	Age	Occupation	(Circle One)
Step-Parents				Living / Deceased
				Living / Deceased

	Name	Age	History of Mental Illness? (if yes, specify
Siblings and/or Stepsiblings			

Significant Family Psychiatric History

Client's Substance/Alcohol History & Daily Usage

Most Recent Use/ of drug and/or Alcohol	Drug (s) of Choice	Drink to Blackout? Last time?	History of Seizures
		Yes No	Yes No

Most Recent Period of Sobriety	Family Hx of Substance Abuse? Who?	IV Drug Use	
		Yes No	

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Have you ever been to Detox/Rehab?		
Dates	**Facility**	**Completed? (If no, why)**

Legal History			
	Date of Arrest / Probation Period	**Court Ruling**	**Comments (weapons, drugs, BAC, etc)**
History of DUI / DWI			
Pending Charges			
Other Charges from Past			

Reason for Coming In for Counseling

Previous Therapists		
Name	**Dates**	**Reason**

Current Risks			
Any Suicidal Ideation/Intent	**(Circle One)** Yes No	When was last time and for how long?	
Self –Harm	**(Circle One)** Yes No	**If yes, please explain**	**Availability and Means**
Homicidal Ideation	**(Circle One)** Yes No	If yes, execute "duty to warn"	
Hx of Violence	**(Circle One)** Yes No	**If yes, explain**	

Client's Signature		Date:	
Therapist's Signature		Date	