

TRILLIUM SPRINGS COUNSELING

1640 Powers Ferry Road, Building 16, Suite 300, Atlanta, Georgia 30067

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 Abuse / Addictions:

FAMILY, FRIENDS, RELATIONSHIPS

C. Family:

1. Mother:
2. Father:
3. Siblings
4. Other Family:

D. Married / Partnered Relationships:

E. Romantic Relationships:

F. Sexual Functioning / Issues:

G. Social Support:

H. Self-Care / Coping Mechanisms:

I. Diet / Exercise:

J. Spirituality

K. Career:

1. Education

2. Current Position:

3. Past Positions:

L. Recommendations / Future Plans / Referral:

M. Client Strengths / Prognosis:

N. Diagnosis / Diagnoses:

- 1. **Axis 1:** _____
- 2. **Axis 2:** _____
- 3. **Axis 3:** _____
- 4. **Axis 4:** _____
- 5. **Axis 5: (GAF):** _____

Mental Status Exam

Appearance: Neat _____ Disheveled _____ Appropriate Attire _____ Affect _____ 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 _____ Normal _____
Thought Content: Normal _____ Hallucinations _____ Delusions _____ Obsessions _____ Ruminating _____ Flight of Ideas _____ Paranoia _____

TREATMENT GOALS

P1 _____

P2 _____

P3 _____

P4 _____

TREATMENT PLANS

T1 _____

Therapist's Signature: _____