Ryan Long, LICSW
3000 Connecticut Ave. NW
Suite 436
Washington DC, 20008

Date of Intake*:*_____

Name: _____

Address:_____

_____

Place of birth: _____ Language: _____

Phone number: _____ Cell number: _____

DOB: _____Age: _____ Race/Ethnicity: _____

Legal Guardian: _____ Phone number: _____

School: _____ Grade: _____

Country of origin (parent): _____ Language: _____

Referral source: _____

Emergency Contact Information:

Name: _____ Relationship:_____
Address:_____

Phone number: _____ Cell number: _____

Other household members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Presenting Problem: (Concerns, Symptoms and History of Present Issues)

_____

_____

_____

_____

_____

Family Background/Dynamics: (Family constellation/interactions/solutions to problems)

_____

_____

_____

_____

_____

_____

History of Physical Abuse/Sexual Abuse/Neglect/Other Significant Traumas:

_____

_____

_____

Substance Abuse Exposure/Use: (Types of Substances, Last Use/Highest Use)- **See sheet with CAGE**

_____

_____

_____

Psychiatric History: (Hospitalization, Outpatient Services)

_____

_____

History of Hallucinations, Anxieties, Phobias, Depression, Sleep Disturbances, Eating Issues:
Social Services Involvement/Name/Phone Number/ Name of Caseworker:

_____

_____

Education

Is child in special education?: Yes No IEP? Yes No

Is child in advance placements? Yes No What subjects?: _____

Previous Mental Health History

Has client received mental health treatment in the past? Yes No Duration: _____

Describe primary reason: _____

Name/phone number of agency: _____

Previous therapist: _____

Reason for discharge: _____

Has client ever seriously thought about suicide? _____ Yes _____ No
Has client ever attempted suicide? _____ Yes _____ No
How many times? _____ Date of most recent attempt _____
Describe most recent attempt

_____

_____

_____

Medical (Allergies/Diseases)

Is client on any medication?: Yes No Name of drug: _____

Dosage: _____Does client have any allergies?: Yes No Specify: _____

Judicial Information

Is client involved in the justice system? Yes No

For what offense? _____

Is counseling court mandated? Yes No

Housing: Lives in: ☐ Single Family Home ☐ Apt. ☐ Shelter ☐ Homeless ☐ Group Home

Number of People Living In Home:

Strengths:

1. _____

2. _____

3. _____

MENTAL STATUS EXAM

Check "Within Normal Limits" or, if "Other," circle the appropriate response(s) or write in alternative.

	WITHIN NORMAL LIMITS	OTHER
Appearance and Behavior Dress and Grooming		☐ Fastidious ☐ Disheveled ☐ Odor ☐ Unkempt ☐ Disorganized ☐ Seductive. ☐ Pseudo-mature ☐ Bizarre ☐ Extreme ☐ Inappropriate
Posture and gait		☐ Rigid ☐ Slow ☐ Retarded ☐ Shaky ☐ Bizarre
Apparent age		☐ Younger or ☐ Older Looking than age
Physical health		☐ Vigorous ☐ Sickly ☐ Frail
Height/Weight		☐ Short or ☐ Tall For age Significantly ☐ Thin or ☐ Obese
Facial expression		☐ Sad ☐ Silly ☐ Bland ☐ Angry
Psychomotor		☐ Uncoordinated ☐ Restless ☐ Pacing ☐ Slow ☐ Muscle rigidity ☐ Disorganized ☐ Hyperkinetic ☐ Agitated ☐ Involuntary movements
Specific mannerisms		☐ Grimaces ☐ Hair pulling ☐ Hand wringing ☐ Hand flapping ☐ Ticks (eye blinking, jerky Movements, sniffling, vocal sounds)
Eye contact		☐ Avoids eye contact ☐ Stares into space ☐ Glances around furtively
Attitude toward Interviewer		☐ Affection-seeking ☐ Seductive ☐ Evasive ☐ Impatient ☐ Apathetic ☐ Remote Mistrustful ☐ ☐ Hostile ☐ Defiant ☐ Withdrawn Other:_____
Mood/Affect		☐ Manic ☐ Depressed ☐ Sad ☐ Up ☐ Down ☐ Angry ☐ Labile ☐ Flat ☐ Inappropriate ☐ Fearful ☐ Worried ☐ Euphoric ☐ Irritable
Speech		☐ Pressured ☐ Rapid ☐ Slow ☐ Mute ☐ Says very little ☐ Garbled ☐ Mumbled ☐ Stuttering ☐ Aphasic ☐ Nonsensical ☐ Articulation ☐ Errors ☐ Illogical ☐ Incoherent ☐ Slurred ☐ Fragmented ☐ Excessive ☐ Language barrier
Thought process		☐ Showed response ☐ Circumstantial ☐ Blocking ☐ Preservation ☐ Tangential ☐ Loose associations ☐ Flight of ideas
Thought Content Distortions		☐ Delusions ☐ Depersonalization ☐ Grandiosity ☐ Paranoia ☐ Ideas of reference

Preoccupations **Suicidal or homicidal**		☐Phobias ☐Obsessions ☐Somatic concerns ☐Ideation ☐ Intention ☐ Actual plan
Perception **Illusions** **Hallucinations**		If Present, Describe: _____ ☐Auditory ☐Visual ☐Olfactory ☐Gustatory ☐Tactile
Intellectual functions **Level of alertness** **Orientation** **Memory** **Immediate** **Recent** **Remote** **Impression of intelligence**		☐Drowsy ☐Vigilant Disorientated to: ☐Time ☐Place ☐Person _____ _____ _____ ☐Very bright ☐Low IQ
Insight		☐Denies or ☐Minimizes illness ☐Denies or ☐Minimizes need for treatment
Judgment		☐Poor ☐ Impulsive

Treatment Recommendations

- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Couples Therapy
- ☐ Psychopharmacology
- ☐ Inpatient Care
- ☐ Substance Abuse Treatment

Referral Recommendations

- ☐ Psychiatric Evaluation
- ☐ Case Management
- ☐ Educational Services
- ☐ Occupational Services
- ☐ Vision Evaluation
- ☐ Hearing Evaluation
- ☐ Group Home/Residential Tx
- ☐ Psych Rehab Evaluation
- ☐ Day Treatment
- ☐ Speech Evaluation
- ☐ Neuropsychologist Testing
- ☐ Psychological Testing
- ☐ Substance Abuse Tx
- ☐ Occupational Therapy Evaluation
- ☐ Nutritional Assessment
- ☐ Other

Additional Clinical Impressions:

_____
_____
_____
_____
_____

_____ _____

Ryan Long, LICSW Date
Psychotherapist