Howard Brockman, LCSW
1620 Commercial St. SE
Salem, OR 97302

INTAKE EVALUATION

Part I To be completed by client

1. IDENTIFYING INFORMATION

Client's Name: _____Today's Date:_____

Partner's Name (if being seen as a couple):_____

Address: _____City, State, Zip:_____

Telephone(s):_____ _____ _____
(home) client (work) partner (work)

May we leave messages for you at home? Yes or No: _____ May we leave messages at work? Yes or No:_____

Gender: M ____ F_ ___ Age: _____ Birth Date: _____ Marital Status: _____

Others living in the home: _____, _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

_____, _____, _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client)

Education: Self:_____ Partner:_____

Occupation: Self_____ Partner:_____

Client's Employer:_____

Social Security (ID) Number: Self:_____ Partner:_____
(optional)

Emergency Contact:_____ Phone:_____

Referred by:_____

Insurance information

Name of insured: _____ Insured date of birth:_____

Address of insured person: _____City, State, Zip: _____

Relationship of client to insured person:_____

Employer of insured person:_____

Insurance company: _____Phone:_____

Insurance company address: _____City, State, Zip:_____

Insurance identification number: _____Group number:_____

Secondary insurance: _____Phone:_____

Name of secondary insured: _____Date of birth:_____

Secondary company address: _____City, State, Zip:_____

Secondary identification number:_____ Group number:_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signed:_____Date:_____

Howard Brockman, LCSW
1620 Commercial St. SE
Salem, OR 97302

Client Name:_____

2. PRESENTING PROBLEMS

Describe the problem that brought you here today:

Depression		Feeling hopeless		(This space reserved for additional comments by clinician)
Extreme sadness		Feeling tearful		
Trouble concentrating		Change in sleeping habits		
Memory problems		Lack of energy		
Change in eating habits		Weight changes		
Feeling of extreme happiness		Change in sexual interest or function		
Trouble performing your job		Problems getting along with friends or family		
Lack of enjoyment of usual activities		Feeling stressed		
Self-esteem problem		Easily irritated		
Perfectionism		Feeling guilty		
Obsessions or eompulsions		Feeling nervous		
Feeling fearful		Sudden feelings of panic		
Physical complaints of pain		Muscle tension		
Problems with anger		Acting violently		
Thoughts about hurting yourself or others		Thoughts about killing yourself or others		

Continued

Howard Brockman, LCSW
1620 Commercial St. SE
Salem, OR 97302

3. HAVE YOU EVER BEEN IN COUNSELING BEFORE? Yes ☐ No ☐

If you have been in counseling before, please describe it below. Start with most recent time first.

A. When did you have counseling?	Date(s):
Who did you see?	Name:
Explain What Happened:	
B. When did you have counseling?	Date(s):
Who did you see?	Name:
Explain What Happened:	

4. MEDICAL INFORMATION

Have you seen a doctor within the past year?	Yes		No		
Why have you seen a doctor?					
Who is your doctor?	Phone:				
Are you taking any kind of medicine? (prescription or over-the-counter)?	Yes		No		
Please list the medicines that you are taking:					
Do you have allergies to anything?	Yes		No		
Please describe allergy problems that you may have:					

5. SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form)?	Current		Past		No	
Do you use/have you used alcohol?	Current		Past		No	
Do you use/have you used caffeine (any form, including cola drinks)?	Current		Past		No	
Do you use/have you used recreational drugs?	Current		Past		No	