Your Name

Student in GCN 601 OA Principles & Methods of Counseling
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Masters in Mental Health Counseling Program
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2 Washington Street, New York, NY 10004 (646) 378-6000

Intake Report

CONFIDENTIAL

Client Name: Fictitious Name
Address: 2 Washington Street
New York, NY 10004
Gender: Female
DOB: Month xx, Year
Highest Level of Education: Bachelors
Current Employment Status: Unemployed
Current Marital Status: Single
Examiner's Name: Your Name

Supervisor's Name: Michele Hernandez, MA, LPC, NCC, ACS
Date of Interview: 04/xx/2020
Date Report Written: 04/xx/2020
Date Report Submitted: 04/xx/2020

Referral and Purpose of Evaluation:
In this section, the writer should clearly state the referral source and important facts prompting the intake interview.

Description of Client/Behavioral Observations:
The writer should provide the demographics of the client, such as gender, age, ethnicity, immigration status, marital status, educational background, position in nuclear family, position in family of origin, and living arrangement. The client's presentation during the interview such as dress (e.g., casual, appropriate, flamboyant, seductive), grooming (e.g., neat, sloppy, disheveled, smelly), mannerisms (e.g., relaxed, twitching, stiff, flowing gestures), and observed behaviors (e.g., example, cooperative, nervous, pacing, bizarre, foreign accent, degree of eye contact, stuttering). Additionally, the writer should list all sources of information other than the client, including specific relatives and other collaterals, teachers, court reports, school reports, and/or hospital records or documents.

Presenting Problem:
The writer should explain the client's presenting problem as stated in terms of psychiatric symptoms, as specifically as possible, including onset, frequency, duration, intensity, and lability (e.g., mood changes/shifts). The client's expressed affect and levels of stress and distress, pain, and upset should be noted. The impact upon personal, familial, employment and "other" life functioning should be mentioned. Lastly, current concomitant medical or psychiatric illnesses and treatments, including alternative medicine approaches, should be identified.

History of the Illness and Other Relevant History:
The writer should clearly state the onset of the illness/problem. Precipitants or environmental stressors described, such as deaths, lost jobs, etc. should be identified. The course of disorders specified, including the number of previous episodes, length of episodes, length of inter-episode periods; degree of impairment of functioning should be reported. Previous medical and/or psychiatric history treatments should be stated. Siblings, birth order, rearing environment (e.g., foreign country, culture) should be identified. Significant events in early childhood, middle childhood, and adolescence should be explained. Relevant adult history, including work history, dating/marital history, substance use/abuse history, sexual history, interpersonal relationships present and history, legal criminal history, medical history, religious behavior present, and history, leisure activities should be included. Family history of psychiatric illness/problems should be reported. Lastly, history of physical or sexual abuse, sexual assault, or intimate partner violence such as date rape and domestic violence should be identified.

Mental Status Examination:
The writer should identify any unusual client behaviors and observations during the interview. This section should include the client's orientation to person, place, and time. Additionally, the writer should note mood and affect; speech and organization of thought; attention, memory, and concentration; intelligence estimate; reliability of information; judgment and insight into problems; dangerousness (e.g., suicidal and homicidal ideations, plan and intent, risk estimate); absence/presence of hallucinations and delusional beliefs; and use/abuse of alcohol, prescription drugs, street drugs, and herbs. Lastly, the client's strengths, including self-esteem, religious beliefs, social support networks, history of coping and management of life, should be reported.

Clinical Formulation:
The writer should include a theoretical analysis of the current case data provided and hypotheses about the etiology of problems articulated in psychological terms. The writer should highlight symptom constellations from present and historical information, which supports a "most likely" diagnosis and tentative or working diagnoses. The writer should include the rationale that this formulation is supported by authoritative sources such as the DSM-5 or published literature (use APA style in references or quotations); highlight if there is any risk of danger to self or other, and offer any reasons for tentativeness in the conclusions including the need for further assessment.

DSM-5 Diagnosis:
The writer should include all of the applicable diagnoses (full name) as per the DSM-5. The official code numbers should be provided for each diagnosis. For example:

- F32.1 Major Depressive Disorder, Single Episode (Moderate)
- F41.1 Generalized Anxiety Disorder

Tentative Treatment Plan and Goals:
In light of the tentative diagnosis and clinical data, the writer should state the professional treatment recommendation (e.g., cognitive-behavioral individual psychotherapy, dialectic behavior therapy, etc.). Additionally, the tentative short term goals of treatment should be stated (e.g., stabilize mood, reduce the frequency of panic attacks, eliminate or reduce hallucinations).

Suggestions for the most appropriate form of treatment based on outcome research should be identified (use APA style in references or quotations).

Signature and Title:
The writer should include his/her signature in script, in black ink along with his/her printed full name, degree and title, state of licensure and license title, and date of signature. If the writer is an intern or partially licensed, s/he should include his/her supervisor's full name, degree, title, or position in the agency, and signature.

Appendix:
If any sources were cited in the body of the report, the writer should append a reference section. For example, a good portion of the above information can be found in the following reference:

Segal. D. (1998). Writing up the intake interview. In M. Herson, & V. B. Van Hasselt (Eds.), *Basic interviewing: A practical guide for counselors and clinicians* (pp.129-150). USA: Lawrence Erlbaum Associates.