PoloJean-Louis**LCSW**

OFFICIAL WEBSITE: www.polojeanlouis.com

COMPREHENSIVE INTAKE & ASSESSMENT PACKET

INTAKE ASSESSMENT

IDENTIFYING & CONTACT INFORMATION
TREATMENT ISSUE(S)
MENTAL HEALTH SURVEY
MILITARY EXPERIENCE
GENDER, SEXUAL HEALTH, & RELATIONSHIP HISTORY
FAMILY MENTAL HEALTH HISTORY
TRAUMA, GRIEF & LOSS HISTORY
STRENGTHS, OTHER CONCERNS, & GENERAL THERAPEUTIC VIEWS

POLO JEAN-LOUIS, LCSW. LLC
612 GRAY ROAD, GORHAM, MAINE 04038
TELEPHONE: (207) 200-7050 & FAX: (207) 893-1865

INTAKE ASSESSMENT FORM

Please fill out this form. Although all this information can be very helpful in your treatment, please complete what is comfortable for you at this time. *Be aware that the information you provide here is protected as confidential information.* ***(PLEASE PRINT)***

IDENTIFYING & CONTACT INFORMATION:

Client Name:____

(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Current Martial Status: __________________

Name(s) of Custodial Parent/Guardian (if client is a minor):

____

Address:

____

(Street and Number)

____

(City) (State) (Zip)

Home Phone: (______________________) May I leave a message? Yes___ No___

Cell/Other Phone: (______________________) May I leave a message? Yes___ No___

Work Phone: (______________________) Is it OK to call you at work? Yes___ No___

OK to leave a message at work? Yes___ No ___

Email Address: ___________________________________ May we email you? Yes __ No___

***Please note: Email correspondence is not necessarily a confidential medium of communication.**

Please list full name, phone number and relationship of an emergency contact person:

____

____

Ethnic/Racial Identity: ____

Country of Birth: ____

If born in the U.S., what city and state? ____

Religious Preference (if any) ____

TREATMENT ISSUE(S):

What has made you decide to come for counseling now?

____

____

____

In your own words, what is the problem? How do you see the situation?

____

____

____

____

What have you done so far to try to deal with this problem? ________________________

____

____

MENTAL HEALTH SURVEY:

Please rate yourself in each category using the following scales -
0: Never, **1**: Most Rarely, **2**: Mild, **3**: Moderate, **4:** Severe, & **5**: Most Severe.

______ frequent sadness
______ mood swings
______ irritability
______ lack of joy
______ poor concentration
______ low energy
______ intense anxiety
______ panic attacks
______ fears, phobias
______ hearing voices
______ visual hallucinations
______ spiritual concerns
______ overwhelming emotions
______ urges to do things almost against your will

______ memory loss
______ unexplained losses of time
______ feeling you are not in your body
______ a sense of things not being real
______ repetitive thoughts
______ compulsive behaviors
______ frequent physical complaints
______ self-injuring behaviors
______ cutting
______ impulsivity
______ restlessness
______ aggression or uncontrollable rage
______ no sense of emotions

_______ sexual identity issues
_______ gender identity issues
_______ feeling isolated
_______ ideas to hurt yourself
_______ alcohol use
_______ recreational drug use
_______ physical abuse
_______ emotional abuse
_______ sexual abuse &/or exploitation
_______ eating disorders
_______hopelessness
_______low self-esteem

______ irresistible feelings of having to do certain things before you can go on with other activities. If so, please describe: ____

____

_____ sexual problems (please briefly describe):________________________________

____

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Do you have a medical doctor? Yes___ No ____
If so, please list name and phone number:____

____

When was the date of your last physical? ____

How would you rate your current physical health? (Please Circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

____

____

____

How would you rate your current sleep habits? (Please Circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems:____

____

How many times per week do you generally exercise? _____________________________________
LIst the types of exercise do you participate in:

____

____

Please list any difficulties you experience with your appetite or eating patterns:

____

Are you currently experiencing any chronic pain? Yes___ No____
If yes, please describe:

____

____

Do you drink alcohol more than once a week? Yes___ No ___
If yes, describe what kind and quantity of use

____

____

Do you engage in recreational drug use? Yes___ No____ IV DRUG USE: Yes___ No____
If yes, how often: Daily___ Weekly___ Monthly___ Infrequently___ Never___
Drug(s) of choice and amount of use:

____

____

How do you feel about your body? ____

____

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
Yes___ No ____ 1st visit:____________ Most recent visit: ___________________
If yes, please list name of service provider: ____
____

If you were previously given a mental health diagnosis, please list all here:
____
____
____

Have you been psychiatrically hospitalized in the last 12 months? ______ If so, when? _________________
What happened?
____
____
____

Have you ever previously been on psychiatric medication? Yes___ No___
If yes, please list and provide approximate dates: ____
____

Are you currently on psychiatric or any other medications? Yes___ No ___
If yes, please list____
____
____

Have you had experiences at any time in your life that were frightening, disturbing, or especially uncomfortable for you? Yes_____ No _____
If yes, we will discuss this when you are ready, unless you wish to indicate it here:
____
____
____

Have you had any previous suicide attempts? Yes___ No___
If so, when?____
What was your method? ____________________________________ Were you hospitalized? Yes ___ No ___
Did you have any follow-up counseling? ____

Do you have any current suicidal thoughts? Yes___ No ____

Do you have thoughts of harming someone else? Yes___ No____

Are you sometimes aggressive, irritable, and/or impulsive? Yes___ No ___

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If so, which and in what conditions?

____

____

____

Have you ever caused any damage to anyone or anything as a result? Yes ___ No ___ If so what?

____

____

If you do have any thoughts of wanting to harm yourself or someone else, do they feel irresistible?
Yes___ No _____ Are these thoughts concerning to you? Yes___ No ___
If so, what is concerning about them?

____

____

MILITARY EXPERIENCE:

Have you served in the Military? ___Yes ___No
If yes: __Current ___Past
Date of enlistment: ______________________________
Branch of Service in which you serve(d):
______ Navy _____ Army _____ Coast Guard _____ Air Force _____ Marines

Type of Discharge Received:
______ Honorable ______ General (under honorable conditions) _____ Other than honorable
______ Bad Conduct ______ Dishonorable ______ Other (Specify)___________________________

Date of Discharge: ________________________________

GENDER, SEXUAL HEALTH, & RELATIONSHIP HISTORY:

Sexual Orientation: (Check all that apply)
__ Heterosexual __ Asexual __ Bisexual __ Gay __ Lesbian
__ Questioning __ Unknown __ Other (specify)_____________________________

Gender Identification: (Check all that apply)
__ Female __ Male
__ Transgender: male to female __ Transgender: female to male
__ Unknown/unsure __ Inter-sexed __ Other: ________________________

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Do you have concerns or issues related to sexual orientation or gender identification? ____Yes ____No
If Yes, please
describe:____
____
____

Are you now or ever have been married or involved in committed relationships?
___ Yes ___ No
If yes, please describe past and current relationships (# of marriages, divorces, committed relationships, length of each relationship, etc.)
____
____
____
____

Behavior Risk for HIV or AIDS infection? ___ High ___ Low ___ Unknown
Comments:____

Is there any issue with the following behaviors? (Check all that apply)

- __ No reports of inappropriate sexualized behavior
- __ Client chooses not to respond at this time
- __ Provocative behavior: dangerous/risky
- __ Prostitution
- __ Inappropriate online activity
- __ Masturbates in public or frequently
- __ Sexually coercive to others
- __ Other
- __ Conviction of a sex crime/On the sex registry
- __ Clinician chooses not to ask at this time
- __ Promiscuous Behavior: dangerous/risky
- __ Online pornography
- __ Exposing self
- __ Verbal abuse w/sexual overtones
- __ Sexually aggressive toward partner

If yes to any of the above, is this affecting your quality of Life?
____
____
____

Using the following scale:
0: Poor/Tragic, **1**: Quite Poor, **2**: Less than Fair, **3**: Fair, **4**: Good, & **5:** Great/No Issues

How would you rate your relationship with your partner? ___________ Sex?:__________Intimacy?:__________

How many prior romantic relationships have you had? ___________ Marriages?: ____________

Do you have any children? Yes ___ No ___ If yes, how many? _____
Please list ages and genders ____
____

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Do you have a good/healthy relationship with your children? Yes ___ No ____
If so, what is good ______________________________
If not, what is not ______________________________

Who, if anyone, currently lives in the same residence as you? ______________________________

Briefly tell me about your family-of-origin (i.e., age and status of parents ((if deceased how and when)), life with biological/adoptive/step parents, siblings, stable/chaotic home, frequent moves, and/or strengths, & stressors, etc)

____
____
____
____
____

Are your current relationships with your parents/siblings satisfying to you? Yes___ No___
If no, what is not?______________________________
____

Are you satisfied with your friendships? Yes___ No___
If not, what is not good?______________________________

What other activities fill your days? ______________________________
____
____

Do you find them satisfying? Yes ___ No ___

Please list the roles you have in life (i.e., mother, student, athlete, etc.): ______________________________
____
____

Do you find these roles meaningful to you? Yes ____ No ____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.). Just indicate the relationship—Names are not necessary.

Alcohol/Substance Abuse:	Yes___	No___	Who:______________________________
Anxiety:	Yes___	No___	Who:______________________________
Depression:	Yes ___	No___	Who: ______________________________
Bipolar Disorder:	Yes ___	No___	Who:______________________________
Domestic Violence:	Yes___	No___	Who:______________________________
Eating Disorders:	Yes___	No___	Who:______________________________

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Attention Deficit Disorder: Yes___ No ___ Who: ____
Obsessive Compulsive Behavior: Yes ___No___ Who: ____
Schizophrenia: Yes___ No ___ Who: ____
Suicide Attempts: Yes ___ No ___ Who: ____

WORK, EDUCATION, & LEGAL HISTORY:

What do you do professionally?
____
Explain why you enjoy it or not?
____
____
____

What is your academic history/highest level of education? (high school, college, advanced, vocational training, etc) ____________________Where did you attend?_______________________________________
Are you satisfied with this? Yes___ No ____
If not, what dissatisfies you?
____
____

Was school difficult for you in any way? Yes___ No ___
If so, please describe how:____
____
____

Do you have any past or current legal problems? Yes___ No ___ Sexual Offense(s): Yes_____ No______
If so, please describe:
____
____
____

TRAUMA, GRIEF & LOSS HISTORY:

Has client experienced any abuse, trauma or violence? (Check all that apply)

__ No Self report of abuse, trauma or violence
__ Community Violence
__ Domestic Violence
__ Elder Abuse
__ Emotional Abuse
__ Physical Abuse
__ Physical Neglect
__ Sexual Abuse, Assault, Molestation
__ Witness to Violence
__ Other

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If yes to any of the above, please comment on how these events are affecting quality of life:

____
____
____
____

What significant life changes or stressful events have you experienced in your life, and when?

____
____

Have you had any significant losses in your life? If so, what have they been?

____
____

How do you typically cope with stress or life challenges? ____

____

Do those approaches usually work for you? Yes___ No ___

STRENGTHS, OTHER CONCERNS, & GENERAL THERAPEUTIC VIEWS:

Are you more of a thinker or a feeler? ________________________Do you focus more on who you are or on what you do, or is there even a difference to you? ____

____

What are some of your strengths?

____
____
____
____

What other issues would you like to accomplish in therapy?

____
____
____
____

Do you believe therapy will require that you make some changes in yourself or the ways you do things?
Yes ___ No ___ If so, are you willing to make such changes? Yes ___ No ___

What makes you believe therapy will be the best way to accomplish these things?

____
____
____
____

What do you want or expect to see in a therapist? ____
____
____

Approximately how many sessions do you anticipate you this will take? ____________

How do you feel about going to therapy?

____
____
____

If you have any questions about anything related to therapy, agency policies, confidentiality, etc..please list your concerns here:

____
____
____
____
____
____

Is there anything else you think I should know that I did not ask?

____
____
____
____
____

I certify I have read the information provided and all the information on this application is correct and was completed to the best of my knowledge.

Client Signature ` Date

It takes great courage to begin the process of counseling. If you have any questions about what to expect in your journey through counseling with me, I am more than happy to discuss this with you not only in our first session together, but throughout the process together. Thank you for engaging in our services. We looking forward to working you and providing you with all our best in helping you live the life you want.

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