DARRELL PHILLIPS
LIVE YOUR LIFE TO ITS FULLEST

DARRELL PHILLIPS
Licensed Clinical Social Worker
5889 Forbes Avenue, Suite 210
Pittsburgh, PA 15217
412.327.2189

Intake Form

Name: ______________________________

Date of birth: ______________________________

Referred by: ______________________________

Career or occupation: ______________________________

Level of education: ______________________________

Spirituality/religion: ______________________________

Briefly describe your presenting concerns:

____

____

____

History of mental health treatment: If yes, list providers and dates of treatment (include hospitalizations).

____

____

____

Please check and describe the following symptoms that apply to you:

☐ Sadness or depressed mood:

____

☐ Low Energy/Fatigue:

____

☐ Guilt/Shame:

____

☐ Irritability/Anger:

____

Client Name:____

☐ **Hyperactivity:**

☐ **Impulsiveness:**

☐ **Elevated Mood:**

☐ **Racing Thoughts:**

☐ **Memory Difficulty:**

☐ **Increased/Decreased Sexual Interest:**

☐ **Decreased Appetite:**

☐ **Difficulty Falling/Staying Asleep:**

☐ **Self Injury Behaviors:**

☐ **Excessive Sleeping:**

☐ **Suicidal Thoughts:**

☐ **Thoughts of Harming Others:**

☐ **Anxiety/Worry:**

☐ **Panic Attacks:**

Client Name:____

☐ **Intruding, Uncomfortable Thoughts:**

☐ **Ruminating Thoughts or Behaviors:**

☐ **Excessive/Perfectionist Behavior:**

☐ **Binging/Purging/Restrictive Eating:**

☐ **Difficulty Trusting Others:**

☐ **Rebellious/Defiant:**

☐ **Abuse or Trauma:**

- ☐ **Emotional:**

- ☐ **Sexual:**

- ☐ **Physical:**

- ☐ **Verbal:**

- ☐ **Bullying:**

Is there a family history of mental health, alcohol or drug problem? If yes, please list and describe:

Client Name:____

Describe any relevant legal issues:

____

____

Describe any other relevant stressors:

____

____

Family:

Name	Relationship to Yourself	Age	Education/Occupation

Medical History. Describe.

☐ Blood Pressure: ____

☐ Diabetes: ____

☐ Thyroid: ____

☐ Heart: ____

☐ Lungs/Breathing: ____

☐ Kidney: ____

☐ Stomach: ____

☐ Seizures: ____

☐ Headaches: ____

☐ Other: ____

Who is your primary care doctor?: ___________________________________

Date of your most recent physical: ___________________________________

Allergies: ____

Client Name:____

History of Substance Use: Describe:

Substance	Age at First Use	Use Last 30 Days	Average Quantity per Use	Last Used	Amount Used
Alcohol					
Sedatives/Barbiturates					
Heroin (Opioids)					
Cocaine					
Other Stimulants					
Marijuana					
Hallucinogenics					

In the past two years, there has been one or more episodes of memory loss due to substance abuse. ☐ No ☐ Yes

____

Personality changes due to the use of substances. ☐ No ☐ Yes

____

In the past 5 years, arrests due to drunkenness/intoxication. ☐ No ☐ Yes

____

Someone close to you thinks you may have a serious substance use problem. ☐ No ☐ Yes

____

There is a history of serious problems with the use of substances. ☐ No ☐ Yes

____

There is a history of substance abuse treatment (may include 12-step program). ☐ No ☐ Yes

____

____
Client Signature

____
Client Print

____
Date