# Steven S. Minter, Th.M., Psy.D.

Clinical Psychology

Licensed Psychologist/PY 8553


INTAKE EVALUATION

Name: _____

DOB: _____ ❑ M ❑ F Age: _____

Ethnicity: _____

**Doctor's Use:**

DOE: _____

Referred by: _____

Accompanying: _____

***In the space below, what brings you in to see Dr. Minter?***


607 South Alexander Street Suite 104
Plant City, FL 33563

**www.minterpsych.com**

Phone: 813.704.4592
Fax: 813.423.6568

*Questions refer to the patient. If completing for a minor, omit questions that do not apply.*

**Social / Family:**

City/State of birth: _____

Setting: ❑ rural ❑ suburban ❑ urban ❑ mixed

Who raised you? _____

Place in sibling birth order: _____ of _____

Names/Ages of Siblings:

How would you characterize your growing up years?

_____

_____

Describe your relationship with your parents:

_____

_____

Spouses'/Partners' names: Children's names and ages:

Currently married/partnered/dating? ❑ yes ❑ no

Describe the relationship: _____

_____

List the members of your household at present:

_____

_____

To whom would you consider yourself particularly close?

_____

_____

**Education:**

Highest grade completed: _____ Earned a:

❑ High School Diploma ❑ GED ❑ None

How were your grades overall? _____

Have you ever:

-had learning problems? ❑ yes ❑ no
-taken special education classes? ❑ yes ❑ no
-repeated a grade? ❑ yes ❑ no
-had conduct problems in school? ❑ yes ❑ no

List any vocational training: _____

_____

List any college/degrees: _____

_____

---

**Occupational:**

Current employer: _____

How do you feel about your present position?

_____

What goals or aspirations do you have for your career?

_____

_____

---

**Legal:**

# times arrested: _____ Charges: _____

_____

Currently involved with legal system? ❑ yes ❑ no

---

**Medical:**

Have you had any history of:

-birth complications? ❑ yes ❑ no
-major surgeries? ❑ yes ❑ no
-overnight hospital stays? ❑ yes ❑ no
-strokes or head injuries? ❑ yes ❑ no
-major illnesses/accidents? ❑ yes ❑ no

List current medical conditions: _____

_____

_____

Describe appetite: _____

Describe sleep: _____

List current medications: _____

_____

_____

Name of PCP: _____

Name of Psychiatrist: _____

**Mental Health/Trauma/Substances/Safety:**

Have you any history of:

| | | |
|---|---|---|
| -psychiatric hospitalizations? | ❑ yes | ❑ no |
| -suicidal thoughts or attempts? | ❑ yes | ❑ no |
| -homicidal thoughts or attempts? | ❑ yes | ❑ no |
| -behavioral outbursts or problems? | ❑ yes | ❑ no |
| -self-harming behaviors? | ❑ yes | ❑ no |
| -hallucinations or delusions? | ❑ yes | ❑ no |
| -psychiatric diagnoses? | ❑ yes | ❑ no |
| -psychotherapy/counseling? | ❑ yes | ❑ no |
| -treatment with medications? | ❑ yes | ❑ no |

Any family history of mental health difficulties/substance abuse?

❑ yes ❑ no Describe: _____

Have you any history of:

| | | |
|---|---|---|
| -childhood neglect or poverty? | ❑ yes | ❑ no |
| -verbal or emotional abuse? | ❑ yes | ❑ no |
| -childhood physical abuse? | ❑ yes | ❑ no |
| -childhood sexual abuse? | ❑ yes | ❑ no |
| -witnessing domestic violence | ❑ yes | ❑ no |
| -adult verbal/emotional abuse? | ❑ yes | ❑ no |
| -adult domestic violence? | ❑ yes | ❑ no |
| -sexual assault/rape? | ❑ yes | ❑ no |
| -witnessing traumatic death? | ❑ yes | ❑ no |
| -surviving natural disaster? | ❑ yes | ❑ no |
| -drug abuse? | ❑ yes | ❑ no |
| -alcohol abuse? | ❑ yes | ❑ no |
| -substance abuse treatment? | ❑ yes | ❑ no |

Current recreational drug use, including cannabis:

_____

Current alcohol use: _____

Has alcohol ever caused problems? ❑ yes ❑ no

History of tobacco use: _____

_____

Have you recently had any thoughts of harming yourself or someone else? ❑ yes ❑ no

If "yes," please describe:

_____

_____

---

**Activities of Daily Living:**

Check any areas in which you are currently having problems:

| | |
|---|---|
| ❑ bathing/dressing yourself | ❑ doing laundry |
| ❑ moving around home | ❑ managing finances |
| ❑ preparing meals | ❑ shopping |
| ❑ doing household chores | ❑ driving |
| ❑ supervising children | ❑ caring for dependents |

What do like to do for fun/recreation/hobbies?

_____

_____

**Current Concerns/Goals:**

Most significant psychological symptoms:

_____
_____
_____
_____

Most significant stressors in your life at this time:

_____
_____
_____
_____

How would you describe your mood today? _____

List 3 things you would like to gain out of therapy:

1. _____
2. _____
3. _____

List 3 strengths you perceive yourself to have:

1. _____
2. _____
3. _____

What else is important for me to know about you as we start?

_____
_____
_____

***Doctor's Use:***

Sx Review:

Working Dx:

Rule Out Dx: