FORMAT FOR WRITING INTAKE REPORTS

This is a guide to help you organize your intake reports. The sample Intake Report provides an example of what should be covered (as well as what I'm looking for).

Page Limit: Five Pages Max.

I. Identifying Information (no heading for this section)

INTAKE REPORT
Pt. Name:
Pt. DOB:
Date of Intake:
Interviewer:

II. Overview (no heading for this section; it just includes a few introductory sentences)

Pt's name and age with a very brief statement of the presenting problem (PP).

III. Presenting Problem and Past History of Emotional Difficulty

Detailed description of the PP, including sx's assessed. History of PP (e.g., when did PP begin; what like up to now). What precipitants led up to the PP, as best you can determine. Situational determinants (as discussed in class). Any treatment for PP. The "best of times" and the "worst of times." Other current problems uncovered during the intake.

Description of past emotional difficulty. State whether or not there has been any past problems of note, and whether or not there has been any past treatment (e.g., for alcohol abuse, depression, anxiety, etc.).

Make sure to include past or present suicidal ideation and/or attempts, any history of aggressive or violent behavior toward others, and any history of delusions and/or hallucinations.

IV. Social History

See sample Intake Report.

V. Educational History

See sample Intake Report.

VI. Occupational History

See sample Intake Report.

VII. Medical History

See sample Intake Report.
VIII. Family, Medical and Psychiatric History

Any significant medical and psychiatric problems in family of origin. See sample Intake Report.

IX. Behavioral Observations

Include any observations you made about non-verbal’s, pt’s dress, demeanor, alertness, level of cooperation, etc. If you’d like, also include a brief description of personality characteristics which you believe may apply (e.g., introverted/walled off or extraverted/outgoing; controlling; submissive; hostile or friendly; dependent; serious-minded or free-wheeling; tight/constricted regarding feelings or openly expresses feelings).

X. Diagnostic Formulation

Give a DSM III-R diagnosis if you were able to collect sufficient information to make a firm diagnosis. You do not need to include the code number of the diagnostic category.

Also include other possible diagnoses which may apply but which you did not assess during the interview. These are called "rule out’s" (see sample Intake Report). This may be one possible diagnosis or more than one. However, only include a rule-out if you have good reason to believe the diagnosis might apply. By specifying a rule-out, your informing yourself (or another therapist) that this diagnosis has not been fully assessed as yet.

This section is very short, including the diagnosis and any relevant rule-out’s, without elaboration.

See sample Intake Report.

XI. Etiological Formulation

This section gives you an opportunity to state your hypotheses regarding the origins of the PP as well as origins of other problems which were uncovered during the interview.

Try to put the pieces of the puzzle together here as best you can, generating your "theory" about the pt’s problem(s).

Don’t go on at length (one-half page maximum).

See sample Intake Report.

XII. Summary and Conclusions

Very briefly (one or two sentences) describe what you believe is the essence of the problem. Indicate whether you believe therapy is indicated and, if so, why and what should be focused on in treatment. See sample Intake Report.