Julia Gerhardt, LCSW, LLC
Intake Self-Assessment

Client Name:	**Signature:**
Date:	**Setting:** Office

Over *the last 7 days,* how often have you been bothered by any of the following symptoms and/or problems?

Depression Assessment Adapted from the PHQ-9
Place one of the following numbers in front of each item: 0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

____Little interest or pleasure in things ____Feeling down, depressed or hopeless ____Trouble falling or staying asleep, or sleeping too much ____Feeling tired or having little energy ____Poor appetite or overeating ____Feeling bad about self or feeling like a failure ____Trouble concentrating ____Moving or speaking slowly or the opposite, being fidgety or restless ____Thoughts that you would be better off dead or hurting yourself in some way

Anxiety Assessment Adapted from DSM V Severity Measure for GAD
Place one of the following numbers in front of each item: 0=Never; 1=Occasionally; 2=Half of the time; 3=Most of the time; 4=All of the time

____Feeling moments of sudden terror, fear or fright ____Feeling anxious, worried or nervous ____Thoughts of bad things happening ____Racing heart, sweaty, trouble breathing, faint or shaky ____Tense muscles, feeling on edge or restless or trouble relaxing ____Avoided, or did not approach or enter situations associated with worry ____Spending a lot of time making decisions, putting off making decisions, or preparing for situations all due to worries ____Sought reassurance from others due to worries ____Needed to cope with anxiety using, for e.g., alcohol or medication, superstitious objects or other people

Safety Assessment: Thoughts of suicide: []No []Yes—[]Ideation []Plan []Intent
Thoughts of homicide: []No []Yes—[]Ideation []Plan []Intent

Briefly state what is bringing you in for therapy at this time in your life:

Please list your goals for therapy: