TRAUMA-FOCUSED INTAKE EVALUATION

Client Name: ____ *Date:* _____

DOB: ___ Age: _ Pronouns: _____

Contact: ____ *Emergency Contact:* ____

Referral Source: _____

PRESENTING CONCERNS

What brings you here today?

Current Trauma-Related Symptoms: ☐ Intrusive memories/flashbacks ☐ Nightmares ☐ Avoidance behaviors ☐ Emotional numbing ☐ Hypervigilance ☐ Startle response ☐ Sleep disturbances ☐ Concentration problems ☐ Dissociation ☐ Panic attacks ☐ Depression ☐ Anxiety ☐ Anger/irritability ☐ Self-harm behaviors ☐ Substance use ☐ Relationship difficulties

Symptom Onset: _____

Triggers (if known): _____

TRAUMA HISTORY

Note: We'll go at your pace. You only share what feels safe today.

Index Trauma (most distressing): ☐ Childhood abuse (physical/sexual/emotional) ☐ Adult assault ☐ Domestic violence ☐ Combat exposure ☐ Serious accident ☐ Medical trauma ☐ Natural disaster ☐ Witnessing violence ☐ Death of loved one ☐ Other: _____

Age when occurred: ___ Duration: __

Relationship to perpetrator (if applicable): ☐ Stranger ☐ Acquaintance ☐ Family member ☐ Partner ☐ Authority figure

Additional Traumatic Events:

Childhood Adverse Experiences: ☐ Physical abuse ☐ Sexual abuse ☐ Emotional abuse ☐ Physical neglect ☐ Emotional neglect ☐ Household dysfunction ☐ Substance abuse in home ☐ Mental illness in family ☐ Domestic violence ☐ Incarcerated family member

TRAUMA SYMPTOMS ASSESSMENT

Re-experiencing (Intrusion): ☐ Distressing memories ☐ Traumatic nightmares ☐ Flashbacks ☐ Psychological distress to reminders ☐ Physical reactions to reminders

Avoidance: ☐ Avoiding trauma-related thoughts/feelings ☐ Avoiding external reminders ☐ Avoiding people, places, activities ☐ Avoiding conversations about trauma

Negative Alterations in Mood/Cognition: ☐ Inability to remember important aspects ☐ Negative beliefs about self/world ☐ Distorted blame of self/others ☐ Persistent negative emotional state ☐ Diminished interest in activities ☐ Detachment from others ☐ Inability to experience positive emotions

Alterations in Arousal/Reactivity: ☐ Irritable/aggressive behavior ☐ Reckless/self-destructive behavior ☐ Hypervigilance ☐ Exaggerated startle ☐ Concentration problems ☐ Sleep disturbance

Dissociative Symptoms: ☐ Depersonalization ☐ Derealization ☐ Memory gaps ☐ "Spacing out" ☐ Feeling disconnected from body ☐ Time loss

COPING AND RESILIENCE

Current Coping Strategies: ☐ Talking to friends/family ☐ Exercise ☐ Creative activities ☐ Spiritual practices ☐ Journaling ☐ Breathing exercises ☐ Meditation ☐ Nature ☐ Pets ☐ Music ☐ Reading ☐ Other: _____

Unhealthy Coping: ☐ Substance use ☐ Self-harm ☐ Isolation ☐ Workaholism ☐ Risky behaviors ☐ Other: _____

Protective Factors: ☐ Strong support system ☐ Stable housing ☐ Financial security ☐ Spiritual beliefs ☐ Sense of purpose ☐ Previous therapy success ☐ Resilient personality ☐ Other: _____

SAFETY ASSESSMENT

Current Safety: ☐ Safe in current environment ☐ Safety concerns present Details: _____

Self-Harm/Suicide Risk: ☐ No current ideation ☐ Passive ideation ☐ Active ideation ☐ Plan/intent Protective factors: _____

Risk to Others: ☐ No concerns ☐ Concerns present Details: _____

SUPPORT SYSTEM

Primary Support People: Name: __ ***Relationship: _ Helpful: ☐ Yes ☐ No Name: __*** Relationship: _____ Helpful: ☐ Yes ☐ No

Family Relationships: ☐ Supportive ☐ Neutral ☐ Strained ☐ Abusive ☐ No contact

Disclosure of Trauma: ☐ No one knows ☐ Few people know ☐ Support system aware Reactions received: _____

PREVIOUS TREATMENT

Trauma-Specific Therapy: ☐ None ☐ EMDR ☐ CPT ☐ PE ☐ TF-CBT ☐ Somatic therapies ☐ Other: _____ Helpful: ☐ Yes ☐ No ☐ Somewhat

Psychiatric Medication: Current: _____ Helpful for trauma symptoms: ☐ Yes ☐ No ☐ Somewhat

CURRENT FUNCTIONING

Work/School Impact: ☐ No impact ☐ Mild impact ☐ Moderate impact ☐ Severe impact Details: _____

Relationship Impact: ☐ No impact ☐ Mild impact ☐ Moderate impact ☐ Severe impact Details: _____

Daily Living Impact: ☐ No impact ☐ Mild impact ☐ Moderate impact ☐ Severe impact Details: _____

TREATMENT GOALS

What would you like to be different? 1. _____ *2.* _____ 3. _____

Therapy Preferences: ☐ Talk therapy ☐ EMDR ☐ Body-based approaches ☐ Creative therapies ☐ Group therapy ☐ No preference

Pace Preference: ☐ Go slow ☐ Moderate pace ☐ Work intensively ☐ Let me decide

CLINICAL NOTES

Trauma Presentation:

Therapeutic Relationship Considerations:

Treatment Recommendations: ☐ Trauma-focused individual therapy ☐ EMDR ☐ Group therapy ☐ Psychiatric evaluation ☐ Medical evaluation ☐ Case management ☐ Other: _____

Frequency: ☐ Weekly ☐ Bi-weekly ☐ As needed

Estimated Treatment Duration: _____

Client Signature: _____ ***Date:*** _

Therapist Signature: _____ **Date:** _____

This information is confidential and protected under HIPAA regulations. Trauma treatment will proceed at your pace with your full consent.