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Adult Intake Form

The following information is requested to best serve you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your therapist. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Date: _____ Date of Birth _____

Name: _____ Age_____ Gender: F_____ M_____

Address: _____

City/State: _____ Zip: _____

Social Security Number _____

Marital Status:

❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Separated ❑ Partnered

Home Phone:_____May we leave a message?

❑ Yes ❑ No

Cell Phone: _____May we leave a message?

❑ Yes ❑ No

E-mail:_____ May we email you?

❑ Yes ❑ No
*Please be aware that email might not be confidential.

Referred By? _____

Primary Care Provider _____Phone Number _____

Emergency Contact Information:

*In Case of Emergency, Contact _____ Relationship to Patient: _____
Home: _____ Work: _____ Cell _____

What are your current emotional or mental-health concerns?
(If you wish, you may rank them in order of seventy, with 1 being most important, and 2 or 3 as a lesser concern to you.)

- ☐ ANXIETY
- ☐ Panic attacks
- ☐ Situational worry ("stress")
- ☐ Preoccupations or obsessions
- ☐ Compulsions or ritual behaviors
- ☐ Intrusive or "taboo" thoughts
- ☐ Avoiding people or places
- ☐ Flashbacks of traumatic events
- ☐ Feeling "jumpy" or easily startled

- ☐ DEPRESSION
- ☐ Persistent sadness
- ☐ Crying spells
- ☐ Despondency or hopelessness
- ☐ Crying spells
- ☐ Despondency or hopelessness
- ☐ Loss of interest
- ☐ Guilt
- ☐ Low energy
- ☐ Low motivation
- ☐ Suicidal thoughts

- ☐ CONCENTRATION PROBLEMS
- ☐ Forgetfulness
- ☐ Easily distracted
- ☐ Easily frustrated
- ☐ Job conflicts
- ☐ Schoolwork problems

- ☐ AGITATION
- ☐ Restlessness
- ☐ Irritability
- ☐ Anger control problems
- ☐ Racing thoughts
- ☐ Rapid mood swings
- ☐ High energy
- ☐ Elevated mood or overly happy
- ☐ Talking too much

- ☐ ALTERNATIVE THOUGHTS
- ☐ Hearing commands/commentary
- ☐ Seeing spirits, auras, other energy
- ☐ Heightened suspicion
- ☐ Paranoia
- ☐ Feelings of being recorded
- ☐ Broadcasting thoughts to others
- ☐ Sensing the thoughts of others

- ☐ SLEEP PROBLEMS
- ☐ I used a sleep aid _____
- ☐ Difficulty falling asleep
- ☐ Frequent awakening
- ☐ Early morning awakening
- ☐ Nightmares
- ☐ Sleep/wake cycle (timing) offset

- ☐ ADDICTIONS
- ☐ Overuse of alcohol
- ☐ Use of street drugs
- ☐ Abuse of prescribed medications
- ☐ Impulsive sexual behaviors
- ☐ Gambling compulsively

- ☐ SAFETY CONCERNS
- ☐ Suicidal ideas
- ☐ Thoughts of harming others
- ☐ _____

- ☐ APPETITE CHANGE
- ☐ Increased appetite
- ☐ Weight gain
- ☐ Decreased appetite
- ☐ Weight loss
- ☐ Anorexia
- ☐ Purging
- ☐ Body image problems

- ☐ PHYSICAL SYMPTOMS
- ☐ Pain
- ☐ Sexual problems
- ☐ Muscle tension (jaw, neck, etc.)

Reason for Visit:

Primary Reason for Seeking Services:

☐ Anger Management ☐ Depression ☐ Mental Confusion ☐ Memory Impairment ☐ Alcohol/drugs
☐ Anxiety ☐ Sexual Concerns ☐ Stress Coping Skills ☐ Fear/Phobias ☐ Sleeping problems

How long ago did these problems begin? _____
Please describe the problems you want help with.

_____
_____
_____

Mood (past 1-2 weeks) ☐ Calm ☐ Happy ☐ Sad ☐ Anxious ☐ Angry ☐ Frustrated ☐ Worried
☐ Hopeless ☐ Helpless ☐ Other _____

Stressors affecting you or your family in the past 1-2 years:

☐ Death	☐ Job Change	☐ Sexual Abuse
☐ Births	☐ School	☐ Broken Relationship
☐ Marriage	☐ Chronic Illness	☐ Unwanted Pregnancy
☐ Divorce	☐ Separation	☐ Substance Abuse
☐ Moving	☐ Physical Abuse	☐ Medical
☐ Job Stress	☐ Other	

Social Relations:
Check how you generally get along with other people: (please check all that apply)

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Leader Follower ☐ Friendly ☐ Fight/Argue
☐ Outgoing ❑ Shy/withdrawn ❑Submissive ☐ Other

FAMILY BACKGROUND and CHILDHOOD HISTORY:

Please list any blood relatives you have with a history of mental health problems:

Difficulty		**Family Member**
Depression:	☐ No ☐ Yes	_____
Bipolar Disorder:	☐ No ☐ Yes	_____
Anxiety Disorders:	☐ No ☐ Yes	_____
Panic Attacks:	☐ No ☐ Yes	_____
Schizophrenia:	☐ No ☐ Yes	_____
Alcohol Abuse:	☐ No ☐ Yes	_____
Drug Abuse/Dependence:	☐ No ☐ Yes	_____
Learning Disabilities:	☐ No ☐ Yes	_____
ADD/ADHD:	☐ No ☐ Yes	_____
Completed Suicide	☐ No ☐ Yes	_____

Please list any blood relatives you have with a history of neurological problems:

Stroke:	☐ No ☐ Yes	_____
Migraine Headaches:	☐ No ☐ Yes	_____
Heart Attack:	☐ No ☐ Yes	_____
Hypertension:	☐ No ☐ Yes	_____
Diabetes:	☐ No ☐ Yes	_____
Parkinsons:	☐ No ☐ Yes	_____
Multiple Sclerosis:	☐ No ☐ Yes	_____
Dementia:	☐ No ☐ Yes	_____
Other:	☐ No ☐ Yes	_____

Were you adopted? ☐ No ☐ Yes,
Where did you grow? _____
List your siblings and their ages: _____
Fathers Occupation: _____

Mothers Occupation: _____

Did your parents' divorce: ❑ Yes ❑ No If so, how old were you? _____

If your parents divorced who did you live with? _____

Describe your father and your relationship with him:

_____

Describe your mother and your relationship with her:

_____

Trauma History:

Are there any, unusual or traumatic circumstance that affected your development?

☐ No ☐ Yes

If yes, please describe: _____

Have you ever been abused?

☐ Emotionally, ☐ Verbally ☐ Sexually ☐ Physically ☐ Neglected

Please describe: _____

_____

Educational History:

Highest grade level completed? _____

Degree obtained? _____

Did you have any disciplinary problems in school? ☐ Yes ☐ No

If yes, please explain: _____

Were you considered hyperactive/ADHD in school? ☐ Yes ☐ No

If yes, were you on any medication? ❑ Yes ☐ No

If so, which medication? _____

Were you diagnosed with any Learning Disabilities in school? ☐ Yes ☐ No

What kind of grades did you get in school?

☐ Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Failing

Employment History:

Are you currently employed?

☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever been fired from a job? ☐ No ☐ Yes (If yes please describe)

_____

How satisfied are you with your current employment?

☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Satisfied

☐ No ☐ Yes Other type discharge _____

Military Service:

Have you ever served in the military? ☐ Yes ☐ No (If so, what branch and when?)_____
Honorable discharge ☐ No ☐ Yes Other type discharge

_____

Relationship History and Current Family:

What is your spouse or significant other's occupation?

_____

Assessment of Current Relationship (If applicable).
☐ Excellent ☐ Good ☐ Poor

Describe your relationship with your spouse or significant other:

_____
_____
_____
_____
_____

Have you had any prior marriages? ☐ Yes ☐ No
If so, how many? How long? _____
Do you have children? ☐ Yes ☐ No.

If yes, list ages and gender:

_____
_____
_____
_____

Describe your relationship with your children:

_____
_____
_____
_____

List everyone who currently lives with you?

_____
_____
_____
_____

RISK ASSESSMENT (Check appropriate boxes):	No	Yes	Recently	Today
1. Been so distressed you seriously wished to end your life?				
2. Have you had or do you have?				
a. A specific plan how you would kill yourself?				
b. Access to weapons/means of hurting self?				
c. Made a serious suicide attempt?				
d. Purposely done something to hurt yourself?				
e. Heard voices telling you to hurt yourself?				
3. Had relatives who attempted or committed suicide?				
4. Had thoughts of killing or seriously hurting someone?				
5. Heard voices telling you to hurt others?				
6. Hurt someone or destroyed property on purpose?				
7. Slapped, kicked, punched someone with intent to harm?				
8. Been arrested or detained for violent behavior?				
9. Been to jail for any reason?				
10. Been on probation for any reason?				

Past Psychiatric History

Outpatient treatment ☐ Yes ☐ No

If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates treated	By whom

Psychiatric Hospitalization ☐ Yes ☐ No

If yes, describe for what reason, when and where.

Reason	Dates Hospitalization	Where

Past Psychiatric Medications:

If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

ANTIDEPRESSANTS		**ANTIANXIETY**		**ADHD MEDICATIONS**	
Zoloft	☐	Xanax	☐	Cylert	☐
Paxil	☐	Valium	☐	Vyvanse	☐
Celexa	☐	Ativan	☐	Adderall	☐
Wellbutrin	☐	Klonopin	☐	Amphetamines	☐
Effexor	☐	Tranxene	☐	Concerta	☐
Elavil	☐	Desyrel (trazodone)	☐	Ritalin	☐
Anafranil	☐	Ambien	☐	**MAJOR TRANQUL**	
Trazodone	☐	Sonata	☐	Risperdal	☐
Remeron	☐	Rozerem	☐	Geodon	☐
Luvox	☐	Restoril	☐	Seroquel	☐
Effexor	☐	**MOOD STABILIZER**		Haldol	☐
Cymbalta	☐	Tegretol	☐	Abilify	☐
Prozac	☐	Lithium	☐	Prolixin	☐
Trintellix	☐	Depakote	☐	Zyprexa	☐
Melatonin	☐	Lamictal	☐	Mellaril	☐
		Topamax (topiramate)	☐		

OTHERS:

Medical Information

Review of Physical Systems: (please check all that apply)

ALLERGIES		GASTROINTESTINAL		MUSCULOSKELETAL	
Environmental Allergies	☐	Peptic ulcer disease	☐	Traumatic Injury	☐
	☐	Hepatitis	☐	Rheumatoid Arthritis	☐
HEAD AND NECK	☐	Irritable Bowel Syndrome	☐	Osteoarthritis	☐
Head trauma with blackout	☐	Acid Reflux	☐	Other musculoskeletal	☐
Other loss of consciousness	☐	**CARDIORESPIRATORY**	☐		☐
Seizure	☐	Asthma	☐	**GENITOURINARY**	☐
Migraine	☐	Respiratory problems	☐	Frequent UTI	☐
Head Trauma without blackout	☐	Cardiac problems	☐	Sexually transmitted disease	☐
CVA or Stroke	☐	COPD	☐	Other Genitourinary	☐
Other head problems	☐	**OTHER**	☐		☐
Epilepsy	☐	Multiple Sclerosis	☐	**IMMUNOLOGIC**	☐
Headaches	☐	Raynaud's	☐	Chronic Fatigue	☐
Mouth problems	☐	Parkinsons	☐	Fibromyalgia	☐
Thyroid problems	☐	Psoriasis	☐	Lupus	☐
Throat problems	☐	Hypertension	☐	Cancer	☐
Sleep Disorder	☐	Diabetes	☐		

Current Medication You Take: (all medications)

Name	Dosage	How often every day?	How long have you been taking it?

Drug Allergies _____

Please do not leave blank, write "none" if no allergies.

Current Weight: _____ Current Height: _____

Pain Levels:

Do you currently have problems with pain? ☐ Yes ☐ No

If yes: Where is your pain located? _____

How long have you had this pain problem? _____

What things help your pain? _____

How intense is your pain today? (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How intense is your average pain? (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How intense is your pain when it is the worse? (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How intense is your pain when it is the least? (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Legal:

Have you ever been arrested? ☐ Yes ☐ No

If Yes, Please List:

_____

_____

Do you have any pending legal problems? ☐ Yes ☐ No

If Yes, Please List:

_____

_____

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No

How much do you drink? _____

How often do you drink? _____

_____

Have you ever passed out or blacked out from drinking? ☐ Yes ☐ No

Have you felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever been cited for driving while intoxicated? ☐ Yes ☐ No

Have you abused prescription medication? ☐ Yes ☐ No

If yes, which ones and for how long? _____

Tobacco Use:

Have you ever smoked cigarettes? ☐ Yes ☐ No

How many packs per day on average? _____

How many years did you smoke? _____

When did you quit? _____

Other Substance Use/Abuse: Do you or did you?

Use medications (other than over the counter) that were not prescribed to you?

☐ In the Past ☐ Recently

Taken more than the recommended daily dose of an over the counter medication?

☐ In the Past ☐ Recently

Taken more than the prescribed dose of your prescription medication?

☐ In the Past ☐ Recently

Taken or used any illegal substance?

☐ In the Past ☐ Recently

Used any product or other means to get high??

☐ In the Past ☐ Recently

OTHER INFORMATION:

What do you like most about yourself?

_____

_____

_____

_____

What do you like least about yourself?

_____

_____

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____