Adult Intake Information

Please provide the following information and answer the questions below. Please complete this form and bring it to your first session. Please note: Information you provide here is protected as confidential information.

GENERAL INFORMATION

1. Client's Name:

_____

(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Gender: ____Male ____Female ____Other Identity

Address: _____City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ - _____ Mobile Phone: ( ) _____ - _____

May we leave a voicemail message? ___Yes ___No

E-mail Address: _____ May we email you? ___Yes ___No

Marital Status:

___Never Married ___Domestic Partnership ___Married

___Separated ___Divorced ___Widowed

Emergency Contact Name: _____ Relationship to Contact: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Please list any other family members living in the same household:

_____

Please list other unrelated people living in the same household:

_____

2. Significant Other's Name: (if applicable)

_____

(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Gender: ____Male ____Female ____Other Identity

Address: _____City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ - _____ Mobile Phone: ( ) _____ - _____

May we leave a voicemail message? ___Yes ___No

E-mail Address: _____ May we email you? ___Yes ___No

May we leave messages with your significant other? ___No ___Yes

3. Primary reason you are coming to see us?

_____

_____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom or problem that is a concern.

_____	Sleep problems	_____	Morbid thoughts
_____	Lack of interest in activities	_____	Suicidal thoughts or threats
_____	Unassertive	_____	Suicidal plans / attempts
_____	Fatigue / Low energy	_____	Mood swings
_____	Concentration problems	_____	Depression
_____	Appetite / weight changes	_____	Changed level of activity
_____	Withdrawal	_____	Cries easily
_____	Forgetful / memory problems	_____	Talks excessively / interrupts
_____	Short attention span	_____	Easily distracted
_____	Aggressive behavior	_____	Irritable
_____	Can't sit still	_____	Impulsive
_____	Not interested in peers	_____	Difficulty following rules
_____	Picked on / bullied by peers	_____	Problem completing schoolwork
_____	Excessive worry / fearfulness	_____	Nightmares
_____	Anxiety or panic attacks	_____	Frequent tantrums
_____	Social fears, shyness	_____	Resistive to change
_____	Separation problems	_____	School refusal
_____	Bedwetting / soiling	_____	Perfectionism

_____	Headaches, stomachaches	_____	Odd hand / motor movement
_____	Odd beliefs / fantasizing	_____	Hallucinations
_____	Lying	_____	Stealing
_____	Trouble with the law	_____	Being destructive
_____	Running away	_____	Fire setting
_____	Truancy / skipping school	_____	Hurting others / fighting
_____	Hurting others sexually	_____	Acts as if has no fear
_____	Alcohol / drug use	_____	Short tempered
_____	Argumentative / defiant	_____	Easily annoyed/annoys others
_____	Swears	_____	Discipline problem
_____	Blames others for mistakes	_____	Angry and resentful

Comments Related to Symptoms or Problems

_____

EDUCATION

____ High School Graduate or GED
____ Associate's Degree
____ Bachelor's Degree
____ Master's Degree
____ PHD

MEDICAL HISTORY

- Current Medical Condition(s) if any:

  _____

- Do you have a Primary Care Physician? ___No ___Yes
- History of medical treatments, serious illness, injury, handicaps, or hospitalization?

  ___No __Yes (provide information for each occurrence)

  History 1

  Date: / / Describe: _____

  Doctor's Name: _____ Hospital: _____

  Current Status or Outcomes?

  _____

History 2

Date: / / Describe: _____

Doctor's Name: _____ Hospital: _____

Current Status or Outcomes?

_____

- Are you currently being seen by another mental healthcare provider? ___No ___Yes
- Have you previously received any type of mental health services (psychotherapy, psychiatric, etc.)? ___No ___Yes (provide information for each occurrence)

  Date: / / Describe: _____

  Counselor's or Doctor's Name: _____

  Hospital: _____ (if applicable)

  Current Status or Outcomes? _____
- Are you currently taking any medications? ___No ___ Yes

  If yes, please list below:

  Medication Name: _____Dosage: _____How Long? _____

  Medication Name: _____Dosage: _____How Long? _____

  Have you ever been prescribed psychiatric medication? ___Yes ___No

  If yes, please list and provide dates:

  Medication Name: _____Dates: _____ to _____

  Medication Name: _____Dates: _____ to _____

- List any medicines previously used for emotional or mental problems: were they helpful?

  _____
- Allergies to drugs or medicines? ___No ___Yes (list) _____+_____
- Allergies to any foods? __No ___Yes (list) _____
- Describe allergic reactions to drugs, medicines or foods: _____

  _____
- Are there any foods that you limit or cannot eat? ___No ___Yes (list)

  _____

- Allergies to environmental conditions? ___No __Yes (list)

  _____

- Does anyone in the household smoke?___ No ___Yes
- Are you afraid someone you know may injure/harm you? ___No ___Yes
- Do you have a Health Care Directive? ___No ___Yes ____ If yes, please list where it is on file

  _____

- Any previous testing (school/psychological)? ___No ___Yes ___Whom/where

  _____when_____

- Do you think you have any chemical dependencies? ___No ___Yes

  Type: ___ Alcohol ____Marijuana ____Other drugs

  Comments:
  _____

- Do you have a history of self-harm or suicidal attempts? ___No ___Yes

  Describe if applicable:

  _____

FAMILY MENTAL HEALTH HISTORY

In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to this person in the space provided (ex. Father, grandmother, uncle, etc.)

	Family Members Relationship
Alcohol/Substance Abuse ___No ___Yes	_____
Anxiety ___No ___Yes	_____
Depression ___No ___Yes	_____
Domestic Violence ___No ___Yes	_____
Eating Disorders ___No ___Yes	_____
Obesity ___No ___Yes	_____
Obsessive Compulsive Behavior ___No ___Yes	_____
Schizophrenia ___No ___Yes	_____
Suicide Attempts ___No ___Yes	_____
Self-Harm ___No ___Yes	_____

Comments related to Family Mental Health History:

_____

LIFE STRESSORS/TRAUMA HISTORY

- Have you ever been a victim of physical abuse? ___No ___Yes

  Specify: _____

- Have you ever been a victim of sexual abuse? ___No ___Yes

  Specify: _____

- Have you ever experienced significant trauma? ___No ___Yes

  Specify: _____

- Other stressors or traumas? _____

ADDITIONAL INFORMATION

1. Are you currently employed? ___No ___Yes
   If yes, what is your current employment situation?
   _____
2. Do you consider yourself to be spiritual or religious? ___No ___Yes
   If yes, describe your/your child's faith or belief: _____
3. What do you consider to be some of your strengths?
4. What do you consider to be some of your weaknesses?
5. What would you like to accomplish during your time in therapy?
6. Any additional comments or information that would be helpful to us?

Signature of person completing this form:

_____ _____ Date: / /

Name Relationship