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ADULT INTAKE FORM

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information.

Client's Name:_____ Today's Date:_____

Client's age:_____ Date of Birth (DOB):_____

Address:_____

Cell phone:_____ May I leave a message? Yes No

Emergency Contact (Name / Relationship to Client / Number): _____

What is the main reason(s) you're seeking help? (Include how long you've had these symptoms or problems): _____

What are your hopes regarding your therapy?

What do you consider to be your strengths?

What do you like most about yourself?

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HEALTH & MENTAL HEALTH INFORMATION

Do you currently have any medical problems?

Have you ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions:

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

Has you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Please list your current prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates):

Do you regularly use alcohol? _____

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

How often do you engage recreational drug use? daily / weekly / monthly / rarely / never

Do you smoke cigarettes or use other tobacco products? _____

Do you or anyone close to you consider your use to be a problem? Yes No

Have you had suicidal thoughts recently? frequently / sometimes / rarely / never

Have you had them in the past? frequently / sometimes / rarely / never

Are you having any problems with your sleep habits? _____

If yes, circle where applicable: sleeping too little / sleeping too much / poor quality sleep / disturbing dreams

Who is your primary care physician? _____

When was your last complete physical exam (mo/year)? _____

How many times a week do you exercise? What type & how many minutes? _____

What types of food do you often eat? _____

INFORMATION

School/Academics

What is the highest grade/degree you completed? _____

Relationships

Are you currently in a romantic relationship? Yes No

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

Occupational Information

Are you currently employed? Yes No

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

Social and Community Engagement

Does you participate in any religious activities? _____

What are your favorite activities or hobbies? _____

In what extracurricular/community activities are you involved? _____

How much are each of the following areas currently a problem for you?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5

Abuse (physical, emotional, sexual) 1 2 3 4 5

Have you experienced any stressors (recent or during the past year) that may be contributing to your difficulties? (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)?

If yes, please describe:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Current age, or If deceased date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old were you when the separation occurred? _____

Siblings

Please list your brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

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In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	
Obsessive Compulsive Behavior	Yes	No	
Depression	Yes	No	
Suicide Attempts	Yes	No	
Bipolar/Manic Depressive	Yes	No	
Alcoholism	Yes	No	
Substance Abuse	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Schizophrenia	Yes	No	
Counseling or Psychotherapy	Yes	No	
Psychiatric Hospitalizations	Yes	No	

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your situation.