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Adult Intake Form

Please provide the following information for my records. Leave blank any question you would rather not answer. Please print out this form and bring it to your first session.

Name: _____
(Last) (First) (MI)

Today's Date ____/____/_____ Your Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female □ Transgender

Address:
_____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No
*Please be aware that email might not be confidential.

Person to contact in case of an emergency:

_____ _____ _____
(Name) (Relationship to you) (Phone)

Marital Status: _____Single _____ Engaged _____Married _____Separated _____ Divorced _____ Widowed _____ Living with Someone _____ Remarried; How many times? _____

Primary Language: _____

Name of Primary Care Physician: _____

Current Employed? □Yes □No _____

Employer Name and Address:

_____

(Street and Number)

_____

(City) (State) (Zip)

Primary Care Doctor:_____ _____

(Name) (Phone)

How did you learn about me?: _____

What prompted you to seek therapy or an assessment at this time?

_____

_____

_____

_____

_____

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □Yes □No

If yes, for how long?_____

If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship? _____

Do you have children? □Yes □No

If yes, how many?: _____ Ages: _____

Have you had previous psychotherapy? □Yes □No

If yes, why? _____

If yes, when?_____

Are you <u>currently</u> taking prescribed psychiatric medications (antidepressants or others)? □Yes □No

If Yes, please list names and doses: _____

_____

If No, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list names and dates: _____

Are you hopeful about your future? □Yes □No

Are you having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

If yes, have you recently done anything to hurt yourself? □Yes □No

Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never", when did you have these thoughts?_____

Did you ever act on them? □Yes □No

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? □Yes □No

Have you previously had homicidal thoughts? □Yes □No

If yes, when?_____

HEALTH INFORMATION

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Date of last physical examination _____

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

_____

_____

Any Allergies? □ Yes □ No If yes, please list:_____

Medications:_____

Hours per night you normally sleep: _____

Are you having any problems with your sleep habits? □ Yes □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Can't fall asleep □ Can't stay asleep

Do you exercise regularly? □ Yes □No

If yes, how many times per week do you exercise? _____ For how long? _____

If yes, what do you do?_____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Purging

Have you experienced significant weight change in the last 2 months? □ Yes □ No

Do you regularly use alcohol? □ Yes □ No

If yes, what is your frequency?

□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

If you checked any box other than "never," which drugs do you use?

_____

Do you smoke? □ Yes □ No

If yes, how many cigarettes per day?_____

Do you drink caffeinated drinks? □ Yes □ No

If yes, # of sodas per day_____ cups of coffee per day_____

Have you ever had a head injury? □ Yes □ No

If yes, when and what happened?

_____

_____

_____

_____

In the last year, have you experienced any significant life changes or stressors?

_____

_____

_____

_____

Are you now experiencing:	*Rating Scale 1-10 (10 =worst) *Note: use rating scale with a "yes" response only.	
Depressed Mood or Sadness	□ Yes □ No	_____
Irritability/Anger	□ Yes □ No	_____
Mood Swings	□ Yes □ No	_____
Rapid Speech	□ Yes □ No	_____
Racing Thoughts	□ Yes □ No	_____
Anxiety or nervousness	□ Yes □ No	_____
Constant Worry	□ Yes □ No	_____
Panic Attacks	□ Yes □ No	_____
Phobias	□ Yes □ No	_____
Sleep Disturbances	□ Yes □ No	_____
Hallucinations	□ Yes □ No	_____
Paranoia	□ Yes □ No	_____
Poor Concentration	□ Yes □ No	_____
Alcohol/Substance Abuse	□ Yes □ No	_____
Frequent Body Complaints (e.g., headaches)	□ Yes □ No	_____
Eating Disorder	□ Yes □ No	_____
Body Image Problems	□ Yes □ No	_____
Repetitive Thoughts (e.g., Obsessions)	□ Yes □ No	_____
Repetitive Behaviors (e.g., counting)	□ Yes □ No	_____
Poor Impulse Control (e.g., ↑ spending)	□ Yes □ No	_____
Self-Mutilation	□ Yes □ No	_____
Sexual Abuse	□ Yes □ No	_____
Physical Abuse	□ Yes □ No	_____
Emotional Abuse	□ Yes □ No	_____

Have you experienced in the past:	*Rating Scale 1-10 (10 =worst)	
Depressed Mood or Sadness	□ Yes □ No	_____
Irritability/Anger	□ Yes □ No	_____
Mood Swings	□ Yes □ No	_____
Rapid Speech	□ Yes □ No	_____
Racing Thoughts	□ Yes □ No	_____
Anxiety	□ Yes □ No	_____
Constant Worry	□ Yes □ No	_____
Panic Attacks	□ Yes □ No	_____
Phobias	□ Yes □ No	_____
Sleep Disturbances	□ Yes □ No	_____

Hallucinations	□ Yes □ No	_____
Paranoia	□ Yes □ No	_____
Poor Concentration	□ Yes □ No	_____
Alcohol/Substance Abuse	□ Yes □ No	_____
Frequent Body Complaints (e.g., headaches)	□ Yes □ No	_____
Eating Disorder	□ Yes □ No	_____
Body Image Problems	□ Yes □ No	_____
Repetitive Thoughts (e.g., Obsessions)	□ Yes □ No	_____
Repetitive Behaviors (e.g., counting)	□ Yes □ No	_____
Poor Impulse Control (e.g., ↑ spending)	□ Yes □ No	_____
Self-Mutilation	□ Yes □ No	_____
Sexual Abuse	□ Yes □ No	_____
Physical Abuse	□ Yes □ No	_____
Emotional Abuse	□ Yes □ No	_____

OCCUPATIONAL, EDUCATIONAL, LEGAL INFORMATION:

Are you employed? □ Yes □ No

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

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

Please list any work-related stressors, if any: _____

Do you have financial concerns? □ Yes □ No

If yes, please explain: _____

Are you currently in the military? □ Yes □ No Previously? □ Yes □ No

Highest level of education:_____

Do you have any legal concerns? □ Yes □ No

If yes, please explain:_____

FAMILY HISTORY:

Are your parents: □ still together
□ divorced, when_____
□ remarried
□ unmarried
□ deceased, if yes whom_____ age at death_____

Number of siblings:_____ Ages:_____

Do you have good family support? □ Yes □ No From whom?_____

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		Family Member(s)
Depression	□ Yes □ No	_____
Bipolar Disorder	□ Yes □ No	_____
Anxiety Disorders	□ Yes □ No	_____
Panic Attacks	□ Yes □ No	_____
Schizophrenia	□ Yes □ No	_____
Alcohol/Substance Abuse	□ Yes □ No	_____
Eating Disorders	□ Yes □ No	_____
Learning Disabilities	□ Yes □ No	_____
Trauma History	□ Yes □ No	_____
Suicide Attempts	□ Yes □ No	_____
Psychiatric Hospitalizations	□ Yes □ No	_____

OTHER INFORMATION:

What role, if any, do religion and/or spirituality play in your life?

_____
_____
_____
_____

Are you satisfied with your social situation/interpersonal relationships? □ Yes □ No

If no, explain why:

_____
_____
_____
_____

What do you consider to be your strengths?

_____
_____
_____
_____

What do you like most about yourself?

_____
_____
_____
_____

What are effective coping strategies you use when stressed?

_____
_____
_____
_____

What are your overall goals for therapy? Or, if you are in need of an assessment, what questions would you like to have answered?

_____
_____
_____
_____

What do you feel you need to work on first?

_____
_____
_____
_____

Is there anything that I did not ask about here that would be important for me to know about you?

_____
_____
_____
_____