Adult Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Today's date:
Name: ____
(Last) (First) (MI)

Birth Date: _____ /_____ /_____ Age: ______ Gender: ☐ Male ☐ Female ☐ Transgender

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

Are you currently in a romantic relationship? ☐Yes ☐No How long?______________

On a scale of 1-10 (10=great), how would you rate the quality of your relationship? ____

Sexual Preference: Men Women Both

Number of Children: _____ Ages: ___________________________

Local Address:

____
(Street and Number)
____
(City) (State) (Zip)

Home Phone: _________________________ May I leave a msg? ☐Yes ☐No

Cell Phone: ___________________________ May I leave a msg? ☐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 client) (Phone)

Referred by: ____

What brought you in to see me today?

Have you had previous psychotherapy? ☐No ☐Yes Reason____________________

Are you currently taking prescribed psychiatric medications (antidepressants or others)?

☐Yes ☐No If Yes, please list: ____

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

If Yes, please list: ____

Are you hopeful about your future? ☐Yes ☐No

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

Have you had suicidal thoughts in the past? ☐ Frequently ☐ Sometimes ☐ Rarely
☐ Never When?____________________

Are you having current homicidal thoughts? ☐Yes ☐No Previously? ☐Yes ☐No

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

____

Medications:____

Primary Care Physician:_________________________ Phone:___________________

3. Are you having any problems with your sleep habits? ☐ No ☐ Yes Hrs/night_____
If yes, check where applicable:
☐ Sleeping too little ☐ Sleeping too much ☐ Can’t fall asleep ☐ Can’t stay asleep

4. How many times per week do you exercise? ______ For how long? ______________

5. Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Purging

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

6. Do you regularly use alcohol? ☐ No ☐ Yes If yes, what is your frequency?

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

7. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What drugs____

8. Do you drink caffeinated drinks? ☐ No ☐ Yes

# of sodas per day______ cups of coffee per day_______

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

________________________________ ________________________________

________________________________ ________________________________

<u>Are you now experiencing (now or in the past)</u>: *Rating Scale 1-10 (10

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 INFORMATION:

Are you employed? ☐ No ☐ Yes
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: ____________________________________

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

Highest level of education:____

Any legal concerns? ☐ No ☐ Yes___________ Financial concerns? ☐ No ☐ Yes__________

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐ No ☐ Yes
If yes, what is your faith? ____

If no, do you consider yourself to be spiritual? ☐ No ☐ Yes

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? ☐ No ☐ Yes By 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**
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 do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies do you use when stressed?

What are your overall goals for therapy?

What do you feel you need work on first?