Adult Intake Form

Please provide the following information for my 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. Please print out this form and bring it to your first session.

Today's Date: ____/____/_____

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

Your Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female □ Transgender Sexual Preference: Men Women Both

Local 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.

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? □No □Yes

If yes, how many?: _____ Ages: _____

HEALTH INFORMATION

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Primary Care doctor:_____ _____
(Name) (Phone)

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

Medications:_____

Hours per night you normally sleep _____

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

If yes, check where applicable:

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

Do you exercise regularly? □ No □ Yes

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? □ No □ Yes

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

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

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

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 cigarettes? □ No □ Yes

If yes, how many cigarettes per day?_____

Do you drink caffeinated drinks? □ No □ Yes

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

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

If yes, when and what happened?_____

PSYCHIATRIC INFORMATION:

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

What are your overall goals for therapy?

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

_____

_____

Have you had previous psychotherapy? □No □Yes

If yes, why?_____

If yes, when?_____

Are you currently 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?_____

Are you **currently** experiencing:			Rating Scale 1-10 (10 =worst) *Only rate the areas to which you say "yes"*
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	_____

Have you experienced in the **past**:			Rating Scale 1-10 (10 =worst) *Only rate the areas to which you said "yes"*
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, FINANCIAL, EDUCATIONAL, & LEGAL 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: _____

Do you have financial concerns? □ No □ Yes

If yes, please explain: _____

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

Highest level of education:_____

Do you have any legal concerns? □ No □ Yes

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? □ No □ Yes 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? □ No □ Yes

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?

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

How did you learn about me?