

**Adult Intake Form**

**Please Print Clearly THIS SHEET MUST BE FILLED IN COMPLETELY**

Client’s Social Security # Client’s Name

Birth date / / Age Gender F M Race

**Referral Source**

How did you hear of us (or from whom)?

Describe the problem that brought you here today: \_

# PRESENTING PROBLEMS AND CONCERNS

|  |  |  |
| --- | --- | --- |
| Distractibility | Change in appetite | Suspicion/paranoia |
| Hyperactivity | Lack of motivation | Racing thoughts |
| Impulsivity | Withdrawal from people | Excessive energy |
| Boredom | Anxiety/worry | Wide mood swings |
| Poor memory/confusion | Panic attacks | Sleep problems |
| Seasonal mood changes | Fear away from home | Nightmares |
| Sadness/depression | Social discomfort | Eating problems |
| Loss of pleasure/interest | Obsessive thoughts | Gambling problems |
| Hopelessness | Compulsive behavior | Computer addiction |
| Thoughts of death | Aggression/fights | Problems with pornography |
| Self-harm behaviors | Frequent arguments | Parenting problems |
| Crying spells | Irritability/anger | Sexual problems |
| Loneliness | Homicidal thoughts | Relationship problems |
| Low self worth | Flashbacks | Work/school problems |
| Guilt/shame | Hearing voices | Alcohol/drug use |
| Fatigue | Visual hallucinations | Recurring, disturbing memories |
| Other: \_ |  |  |

Please check all of the behaviors and symptoms that you consider problematic:

Are your problems affecting any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Handling everyday tasks | Self esteem | Relationships | Hygiene |
| Work/School | Housing | Legal matters | Finances |
| Recreational activities | Sexual activity | Health |  |

Yes No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes,

please describe:\_ \_ \_ \_

Yes No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:\_ \_ \_ \_

Yes No Have you recently been physically hurt or threatened by someone else? If yes,

please describe:\_ \_ \_ \_

|  |  |  |
| --- | --- | --- |
| Yes | No | Have you gambled in the past 6 months? If yes, let us know the following |
|  | Yes | No Have you ever felt the need to bet more and more money? |
|  | Yes | No Have you ever had to lie to people important to you about how much you gambled? |

# FAMILY AND DEVELOPMENTAL HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| Relationship | Name | Age | Quality of Relationship |
| Mother |  |  |  |
| Father |  |  |  |
| Stepmother |  |  |  |
| Stepfather |  |  |  |
| Siblings |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Spouse/partner |  |  |  |
| Children |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Family Mental Health Problems | Who? |
| Hyperactivity |  |
| Sexually Abused |  |
| Depression |  |
| Manic Depression |  |
| Suicide |  |
| Anxiety |  |
| Panic Attacks |  |
| Obsessive-Compulsive |  |
| Anger/Abusive |  |
| Schizophrenia |  |
| Eating Disorder |  |
| Alcohol Abuse |  |
| Drug Abuse |  |

|  |  |  |
| --- | --- | --- |
| Parents legally married or living together | Mother remarried: | Number of times  |
| Parents temporarily separated | Father remarried: | Number of times  |
| Parents divorced or permanently separated |  |  |

Please check if you have experienced any of the following types of trauma or loss:

|  |  |  |
| --- | --- | --- |
| Emotional abuse | Neglect | Lived in a foster home |
| Sexual abuse | Violence in the home | Multiple family moves |
| Physical abuse | Crime victim | Homelessness |
| Parent substance abuse | Parent illness | Loss of a loved one |
| Teen pregnancy | Placed a child for adoption | Financial problems |

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| Therapist Notes: |
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# PREVIOUS MENTAL HEALTH TREATMENT

Yes No Type of Treatment When? Provider/Program Reason for Treatment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Outpatient Counseling |  |  |  |
|  |  | Medication (mental health) |  |  |  |
|  |  | Psychiatric Hospitalization |  |  |  |
|  |  | Drug/Alcohol Treatment |  |  |  |
|  |  | Self-help/Support Groups |  |  |  |

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# SUBSTANCE USE HISTORY

|  |  |  |
| --- | --- | --- |
| Substance Type | Current Use (last 6 months) | Past Use |
|  | Y | N | Frequency | Amount | Y | N | Frequency | Amount |
| Tobacco |  |  |  |  |  |  |  |  |
| Caffeine |  |  |  |  |  |  |  |  |
| Alcohol |  |  |  |  |  |  |  |  |
| Marijuana |  |  |  |  |  |  |  |  |
| Cocaine/crack |  |  |  |  |  |  |  |  |
| Ecstasy |  |  |  |  |  |  |  |  |
| Heroin |  |  |  |  |  |  |  |  |
| Inhalants |  |  |  |  |  |  |  |  |
| Methamphetamines |  |  |  |  |  |  |  |  |
| Pain Killers |  |  |  |  |  |  |  |  |
| PCP/LSD |  |  |  |  |  |  |  |  |
| Steroids |  |  |  |  |  |  |  |  |
| Tranquilizers |  |  |  |  |  |  |  |  |

Yes No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: \_ \_

Yes No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: \_ \_

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# MEDICAL INFORMATION

Date of last physical exam:

Have you experienced any of the following medical conditions during your lifetime?

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies | Asthma | Headaches | Stomach aches |
| Chronic pain | Surgery | Serious accident | Head injury |
| Dizziness/fainting | Meningitis | Seizures | Vision problems |
| High fevers | Diabetes | Hearing problems | Miscarriage |
| Sexually transmitted disease | Abortion | Sleep disorder | Other: \_  |

Please list any CURRENT health concerns: \_ \_

Current prescription medications: None

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Date First Prescribed | Prescribed By |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Current over-the-counter medications (including vitamins, herbal remedies, etc.): \_

 \_ \_ \_ \_\_ Allergies and/or adverse reactions to medications: None

If yes, please list: \_ \_ \_ \_

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# INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

Family Neighbors Friends Students Co-workers Support/Self-Help Group Community Group Religious/Spiritual Center (which one? )

To which cultural or ethnic group do you belong? \_ \_ If you are experiencing any difficulties due to cultural or ethnic issues, please describe: \_

 \_ \_ \_ \_\_

How important are spiritual matters to you? Not at all Little Somewhat Very much

Yes No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents? \_\_ \_ \_

 \_ \_ \_ \_\_ Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):

 \_ \_ \_ \_\_

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## Employment

**MISCELLANEOUS INFORMATION**

Employer: \_ \_ Position: \_ \_ \_ Length of time in this position: \_ Job Duties: \_ \_ Stress level of this position: Low Medium High

Other jobs you have held: \_ \_ \_ \_\_

## Education

Yes No Are you currently attending school?

|  |  |  |
| --- | --- | --- |
| High School Graduate? | Or GED? | Year \_ |
| Associate’s Degree | Year \_ | Major area of study \_ \_ |
| Undergraduate Degree | Year \_ | Major area of study \_ \_ |
| Graduate Degree | Year \_ | Major area of study \_ \_ |

## Military Service

Yes No Have you been/are you currently in the military? (If no, skip remainder of this section)

Branch Date of Discharge \_\_ Type of Discharge \_ \_ Rank Yes No Were you in combat?

## Legal

Yes No Have you ever been convicted of a misdemeanor or felony? If yes, please explain

 \_ \_ \_ Yes No Are you currently involved in any divorce or child custody proceedings? If yes, please

Explain \_ \_

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| --- |
| Therapist Notes: |
|  |
| Therapist Signature DATE: |