

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:

Sexual Preference:

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: _____

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	_____
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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.):

<u>Difficulty</u>		<u>Family Member(s)</u>
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?
