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Adult Intake Form

Thank you for taking the time to complete this form. I realize some of these questions may feel very personal and I ask that you answer them as honestly as you can at this moment and to the best of your ability. You can update information in future sessions, if needed. This information is collected so that together we can determine the best course for your treatment.

Name_____ Preferrred Name_____Birth Date _____ Age_____Date_____

PRESENTING PROBLEM

1. Please state in your own words the problem(s) you are experiencing:

   _____
   _____
   _____
   _____
   _____
   _____
   _____

2. When did this problem begin? _____

3. Therapy can be a powerful force for change. In order for it to be most effective, it helps to have a clear and specific goal. What is your goal in seeking help? Feel free to list more than one goal, if appropriate.

   _____
   _____
   _____

4. Is the use/abuse of drugs and/or alcohol related to this problem in any way? If yes, please explain:

   _____

5. Is there any other behavior that is related to this problem?

   _____

6. Have you experienced any significant loss / crisis / life change recently?

   _____
   _____

Please check any of the following you have experienced recently:

☐anxiety	☐fear	☐hopeless	☐mood swings	☐seeing visions
☐anger	☐flashbacks	☐irritability	☐nightmares	☐social withdrawal
☐appetite change	☐guilt/shame	☐loneliness	☐numbness	☐sleep problems
☐confusion	☐headaches	☐loss of energy	☐pain	☐stomach problems
☐depression	☐hearing voices	☐low impulse control	☐panic	☐stress
☐despair	☐helpless	☐major illness	☐paranoia	☐suicidal thoughts
☐dizziness	☐high energy	☐marital distress	☐poor concentration	
☐fatigue	☐homicidal thoughts	☐memory problems	☐racing thoughts	

☐other (explain) _____

HEALTH HISTORY

1. Are you presently under the care of any medical doctor / practitioner? ☐ Yes ☐No

   If yes, for what condition?_____

   Doctor's name:_____ Phone:_____

2. Are you currently taking any prescription or non-prescription medications? ☐Yes ☐No
   If yes, please complete the following:

Medication	Dosage	How often taken	Reason for taking it

3. Do you smoke or use tobacco products? ☐Yes ☐ No

   If yes, please describe type and frequency of use:_____

4. How much caffeine (including energy drinks/supplements) do you use daily? _____

5. Do you drink alcohol? ☐Yes ☐No

   If yes, please describe how frequent and what type: _____

6. Do you use drugs? ☐Yes ☐No
7.
   If yes, please describe how frequent and what type: _____

8. Are you aware of any physical problems that impair your functioning? ☐Yes ☐No

   If yes, please explain_____

9. Are you currently receiving or have you in the last 3 years received counseling, individual or marital therapy, or been under the care of any mental health provider or addiction recovery provider?

   Provider's Name_____ Phone:_____

   For what issue_____

10. May I contact this provider for additional information? ☐Yes ☐No **(If you answered yes, please fill out and sign a release of information form for this provider)**

11. Do you have any thoughts of hurting yourself or others? If yes explain:

    _____

12. Have you ever attempted to commit suicide? If yes, explain:

    _____

13. Have you ever been hospitalized or been in an outpatient program for a mental health or substance abuse issue? ☐Yes ☐No

    If yes, please list when, where and for what issue: _____

    _____

14. Do you have any current problems with your regular diet? ☐Yes ☐No If yes, please explain:_____

    _____

EXERCISE

1. Do you engage in any form of exercise? ☐Yes ☐No If yes, please explain, how often and what kind: _____

   _____

FAMILY INFORMATION

1. Marital Status: ☐Single ☐In a committed relationship ☐Engaged ☐Married ☐Divorced ☐Widowed
2. Name of Spouse/Partner_____ Age _____ Years together/married _____
3. Spouse/Partner's Occupation_____ Employer_____
4. This is your _____marriage. This is your spouse's _____marriage.
5. How would you describe your current relationship? _____
   _____
6. Names and ages of children (indicate child/children from previous marriage with "P", adopted child/children with "A", and step child/children with "S"). Please also describe your relationship with each child in a few words.
   _____
   _____
   _____
7. Where were you born? _____How long did you live there? _____Ethnicity_____
8. Who did you live with in your household growing up? _____
9. What was your relationship like with your caretakers? _____
10. Does anyone in your family (parent, sibling, child, grandparent, aunt/uncle, cousin) have a mental health condition? If so, what condition and what is their relationship to you?
    _____
    _____
    _____
11. Parents divorced? ☐Yes ☐No If yes, what year_____ Your age at that time_____
12. Family Alcoholism/Drug Addiction? ☐Yes ☐No If yes, please describe: _____
13. Family History of Domestic Violence? ☐Yes ☐No If yes, please describe: _____
14. Are any of your caretakers deceased? ☐Yes ☐No If so, which ones and what year?_____

    Your age at the time_____ Cause of death_____
15. Any step-parents? ☐Yes ☐No If yes, describe when and your relationship with them_____
    _____
16. If reared by someone other than your birth parents, describe the situation in some detail_____
    _____
    _____

SOCIAL SUPPORT

1. Who do you consider part of your social support system?
   _____
2. How satisfied are you with your current level of social support?
   _____

HOBBIES/INTERESTS

1. List any hobbies/interests _____
2. How often do you engage in them? _____

WORK HISTORY

1. Occupation_____Employer_____

2. **Please check any that apply to you**:

☐Job stress
☐Recently laid off or fired from a job/position ☐Problems with co-workers
☐Problems with supervisors or management
☐Problems with job performance ☐Other, explain:

LEGAL HISTORY

1. Have you ever been arrested? ☐Yes ☐No If yes, please explain: _____
_____

2. Are you currently involved in, or anticipate being involved in any litigation or legal action? ☐ Yes ☐No If yes, please explain:_____

SPIRITUALITY/RELIGION HISTORY

1. Please check which of the below describes you best:

☐Religious and participate in a religious community
☐Religious and do not attend church or religious community regularly
☐Believe in God (or Gods) but do not believe in "organized religion"
☐Spiritual but not religious
☐Not sure/uncertain about spiritual beliefs
☐No longer believe in a God (or Gods)
☐Do not and have never believed in a God (or Gods)

2. What is your religious preference/spiritual belief? _____

3. Does your religious preference or spiritual belief help you or hurt you? Please describe: _____
_____

SEXUAL/REPRODUCTIVE HISTORY

1. Are you sexually active? ☐Yes ☐No
2. If yes, do you use contraception? ☐Yes ☐No
3. If yes, do you practice safe sex? ☐Yes ☐No
4. Are there any issues with sexual functioning, sexual preferences or performance, or other related issues that you would like to discuss with me? ☐Yes ☐No If yes, please provide a brief explanation: _____
_____
_____

OTHER QUESTIONS

How do you handle anger?

_____

_____

How do you handle stressful life events? _____

_____

What are your strengths? _____

_____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

_____

_____

_____