



ADULT INTAKE FORM

PATIENT INFORMATION

Name: _____
First Last
Date of Birth: _____ Age: _____ Gender: _____ Race: _____
Address: _____
Street City State Zip
Phone number(s): _____
Home Cell Work
E-mail address: _____

REFERRAL INFORMATION

Who referred you to this practice? Name: _____
Address: _____
Phone: _____ Fax: _____

PRESENTING PROBLEM

What is the **PROBLEM** for which you are seeking assistance? _____

When did you first notice this problem? _____
What caused you to seek treatment at this time? _____

How has this problem affected your **ABILITY TO FUNCTION**? At home: _____

At school/work: _____

In your community: _____

What are the **LIFE STRESSORS** that contribute to this problem? _____

What are **SPECIFIC GOALS** you want to accomplish by being in treatment? How do you want your life to be different? _____

SYMPTOM CHECKLISTS: Please indicate if you have experienced any of the following in the past two weeks. CIRCLE THE ITEM IF IT HAS BEEN LONG-STANDING OR SEEMS TO BE PART OF YOUR PERSONALITY.

DEPRESSION

- | | | |
|--|---|---|
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Self-criticism/Blame | <input type="checkbox"/> Loss of Energy/Fatigue |
| <input type="checkbox"/> Hopeless/Discouraged | <input type="checkbox"/> Hurting Yourself/Want to | <input type="checkbox"/> Sleep Problems _____ |
| <input type="checkbox"/> Feelings of Failure | <input type="checkbox"/> Suicidal Thoughts/wishes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Feeling Helpless | <input type="checkbox"/> Crying | <input type="checkbox"/> Appetite Change +/- |
| <input type="checkbox"/> Loss of Pleasure/Interest | <input type="checkbox"/> Agitation / Restlessness | <input type="checkbox"/> Weight Gain/Loss __lbs. |
| <input type="checkbox"/> Feelings of Guilt | <input type="checkbox"/> Social Withdrawal | <input type="checkbox"/> Concentration Difficulty |
| <input type="checkbox"/> Feeling Punished | <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Loss of Confidence | <input type="checkbox"/> Feeling Worthless | <input type="checkbox"/> Loss of Interest in Sex |

BIPOLAR DISORDER

- | | | |
|---|---|--|
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> High Level of Energy | <input type="checkbox"/> Irritable/Argumentative |
| <input type="checkbox"/> Feeling "High" w/o drugs | <input type="checkbox"/> Unusually Active | <input type="checkbox"/> Jumpy/Can't Relax |
| <input type="checkbox"/> Elevated Self-Confidence | <input type="checkbox"/> Unusually Productive | <input type="checkbox"/> Excessive Spending |
| <input type="checkbox"/> More Outgoing/ Sociable | <input type="checkbox"/> Can't Focus on Tasks | <input type="checkbox"/> Inapp. Sexual Behaviors |
| <input type="checkbox"/> Talking More or Faster | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Other Risky Behaviors |
| <input type="checkbox"/> Little Need for Sleep | <input type="checkbox"/> Can't Shut Mind Off | |

POSTTRAUMATIC STRESS DISORDER

- | | | |
|--|--|---|
| <input type="checkbox"/> Traumatic Memories | <input type="checkbox"/> Avoids Reminders | <input type="checkbox"/> Emotional Numbness |
| <input type="checkbox"/> Distressed at Reminders | <input type="checkbox"/> Frequent Nightmares | <input type="checkbox"/> Can't Remember Event |
| <input type="checkbox"/> Easily Startled / Aroused | <input type="checkbox"/> Flashbacks | |

ANXIETY

- | | | |
|---|---|--|
| <input type="checkbox"/> Constant Worrying | <input type="checkbox"/> Hands Trembling | <input type="checkbox"/> Unable to Relax |
| <input type="checkbox"/> Fear of the Worst | <input type="checkbox"/> Shaky | <input type="checkbox"/> Muscle Tension |
| <input type="checkbox"/> Scared/Terrified | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Dizzy/Lightheaded/Faint |
| <input type="checkbox"/> Feeling Hot/Face Flushed | <input type="checkbox"/> Nervous/Jittery | <input type="checkbox"/> Heart Pounding/Racing |
| <input type="checkbox"/> Sweating w/o Heat | <input type="checkbox"/> Fear of Losing Control | <input type="checkbox"/> Feelings of Choking |
| <input type="checkbox"/> Wobbliness in Legs | <input type="checkbox"/> Fear of Going Crazy | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Unsteady | <input type="checkbox"/> Fear of Dying | <input type="checkbox"/> Abdominal Discomfort |

SOCIAL ANXIETY

- | | | |
|--|---|---|
| <input type="checkbox"/> Shy/Timid | <input type="checkbox"/> Avoiding Public Places | <input type="checkbox"/> Dislike Attention on You |
| <input type="checkbox"/> Avoiding Crowds | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Feeling Judged by Others |

OBSESSIVE COMPULSIVE DISORDER

- | | |
|--|--|
| <input type="checkbox"/> Obsessive Thoughts | <input type="checkbox"/> Compulsive Counting |
| <input type="checkbox"/> Repetitive Thoughts | <input type="checkbox"/> Compulsive “Checking” |
| <input type="checkbox"/> Compulsive Hand Washing | <input type="checkbox"/> Compulsive Neatness |

ATTENTION/HYPERACTIVITY PROBLEMS

- | | | |
|--|---|--|
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Indecisive |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Procrastinates | <input type="checkbox"/> Can’t Sit Still |
| <input type="checkbox"/> Many Unfinished Tasks | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Leaves Seat |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Misplaces Things | <input type="checkbox"/> Interrupts Others |

BEHAVIORAL PROBLEMS

- | | | |
|--|--|--|
| <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Destroying Property | <input type="checkbox"/> Fire Setting |
| <input type="checkbox"/> Extreme Anger or Rage | <input type="checkbox"/> Throwing Things | <input type="checkbox"/> Hurting Animals |
| <input type="checkbox"/> Verbal Altercations | | |

EATING DISORDERS

- | | | |
|--|---|---|
| <input type="checkbox"/> Fear of Weight Gain | <input type="checkbox"/> Distorted Body Image | <input type="checkbox"/> Excessive Dieting |
| <input type="checkbox"/> Binging/Purging | <input type="checkbox"/> Excessive Exercising | <input type="checkbox"/> Excessive Overeating |

DISSOCIATION

- | | |
|--|--|
| <input type="checkbox"/> Feeling Outside Your Body | <input type="checkbox"/> Time Elapsed, No Memory |
| <input type="checkbox"/> Things Feel “Not Real” | <input type="checkbox"/> Gaps in Knowledge |

PSYCHOSIS

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Hearing Voices Others Don’t | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Seeing Things Others Don’t | <input type="checkbox"/> Delusions |

AUTISM SPECTRUM DISORDER

- | | |
|---|---|
| <input type="checkbox"/> Socially Unconnected/Awkward | <input type="checkbox"/> Rigidity/Inflexibility |
| <input type="checkbox"/> Avoids Eye Contact | <input type="checkbox"/> Unusual Repetitive Behaviors |
| <input type="checkbox"/> Language Impairments | <input type="checkbox"/> Intense Preoccupation with Subject |

MENTAL HEALTH HISTORY

Have you recently experienced a **SIGNIFICANT LOSS**? _____ If yes, please explain: _____

Have you ever been the **VICTIM OF ABUSE** (Physical, Emotional, Mental, Verbal or Sexual)? _____
Or the **VICTIM OF DOMESTIC VIOLENCE**? _____ Or the **VICTIM OF NEGLECT** (Emotional or Physical)? _____
If yes, please circle all that apply and explain (if you are comfortable doing so): _____

Have you ever been a **WITNESS OF VIOLENCE, ABUSE OR NEGLECT**? _____ If yes, please explain. _____

Have you ever been the **PERPETRATOR OF VIOLENCE, ABUSE OR NEGLECT**? _____ If yes, please explain. _____

Have you ever **HARMED YOURSELF INTENTIONALLY**? _____ **ATTEMPTED SUICIDE**? _____
If yes, please explain. _____

MENTAL HEALTH DIAGNOSES: please REVIEW THE LIST BELOW and consider yourself, your immediate family, and all of your relatives on both sides of your family. (Maternal is your mother's side of the family and Paternal is your father's side of the family.) Include parents, brothers, sisters, aunts, uncles, grandparents, and first cousins.

IF YOU (OR A RELATIVE) HAVE BEEN DIAGNOSED WITH ANY OF THESE DISORDERS, CHECK THE APPROPRIATE BOX (ES). If a relative, describe his/her relation to you (such as maternal grandfather) and his/her treatment history (if applicable). *We ask for your treatment history elsewhere.*

You Relative

- ADD/ADHD _____
- Autism / Asperger's / Pervasive Developmental Disorder _____
- Learning disabilities _____
- Mental retardation/Intellectual Disability _____
- Speech or Language Disorder _____
- Alcohol/Drug Dependence/Abuse _____
- Anger Problems/Intermittent Explosive Disorder _____
- Anxiety (Chronic Worrying) _____
- Body-Focused Repetitive Behaviors (Skin Picking, Hair Pulling) _____

You Relative

- OCD (Obsessive Compulsive Disorder) _____
- Panic Disorder _____
- Phobias _____
- Social Anxiety _____
- Depression/Dysthymia _____
- Bipolar Disorder (Manic Depression) _____
- PTSD (Post Traumatic Stress Disorder) _____
- Self harm/Self-mutilation _____
- Suicide, Attempted/Completed _____
- Eating Disorders _____
- Nervous breakdown _____
- Schizophrenia or Other Psychosis _____
- Seizures or Other Neurological Disorder _____
- Other _____

OUTPATIENT TREATMENT: Are you now receiving treatment, or have you received treatment in the past, for any of the problems above? _____ If yes, please give information below:

Name	Location	When	For how long?	Problem/Diagnosis
------	----------	------	---------------	-------------------

Therapist: _____

Psychiatrist: _____

PSYCHIATRIC HOSPITALIZATION OR INTENSIVE DAY TREATMENT PROGRAM:

Where	When (month/year)	Type and Length of Stay	Diagnosis	Was it Productive?
-------	-------------------	-------------------------	-----------	--------------------

CURRENT PSYCHIATRIC MEDICATION:

Name	Dosage	When Prescribed	Who Prescribed	Response
------	--------	-----------------	----------------	----------

Do you take your medication as prescribed? _____ If not, please explain: _____

PREVIOUS PSYCHIATRIC MEDICATION (if more than 12 medications, please attach a separate list):

Name	Highest Dosage	Duration of Use	Response	Reason for Stopping

SUBSTANCE USE:

Type	Average Usage	Current	Past	When Last Used
Caffeine		<input type="checkbox"/>	<input type="checkbox"/>	
Nicotine		<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol		<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana		<input type="checkbox"/>	<input type="checkbox"/>	
Inhalants		<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinogens (LSD/Ecstasy/PCP/Mushrooms)		<input type="checkbox"/>	<input type="checkbox"/>	
Opiates (Heroin/Morphine/Other Narcotics)		<input type="checkbox"/>	<input type="checkbox"/>	
Sedatives		<input type="checkbox"/>	<input type="checkbox"/>	
Steroids		<input type="checkbox"/>	<input type="checkbox"/>	
Stimulants (Meth/Crack/Cocaine/Crank)		<input type="checkbox"/>	<input type="checkbox"/>	
Synthetic Drugs/Bath Salts		<input type="checkbox"/>	<input type="checkbox"/>	
Misuse of Other Prescription Drugs		<input type="checkbox"/>	<input type="checkbox"/>	

INDIVIDUAL / GROUP SUBSTANCE ABUSE TREATMENT (AA, NA, etc.):

Year	Program	Was It Voluntary or Court Mandated?	Was It Productive?

SUPPORT GROUP ATTENDANCE for other issues (AL-ANON, ACOA, CoDA, OA, etc.)? _____

If yes, please explain: _____

SOCIAL HISTORY

PERSONAL MARITAL / RELATIONSHIP STATUS:

Single Married Cohabiting Engaged Separated Divorced Re-married Widowed

Current Spouse or Partner (if applicable) _____ Age _____

Years Married /Together _____ Describe your Relationship _____

Number of times Married? _____ Divorced? _____ Widowed? _____

Please List Previous Marriages / Long-term Relationships in order of occurrence (If applicable):

Name	Number of Years Together	Children?	Reason for End
------	--------------------------	-----------	----------------

CHILDREN: Please list ALL Children (including step-children and children who do not live with you):

Name of Child	Age	Sex	Live with you?	Describe your relationship with him/her.
---------------	-----	-----	----------------	--

Please list all others who live/stay with you and their relation to you: _____

PARENTS: Please indicate the current marital/relationship status of your parents:

Married Cohabiting Separated Divorced Re-married Widowed

Father's Name: _____ Mother's Name: _____

How would you describe their relationship with each other when you were growing up? _____

If your parents are Divorced, how old were you at the time? _____

If one or both Re-married, how old were you at the time? _____

With whom did you live afterward? _____

Are your parents still living? _____ If not, please list which is deceased, the year, and the cause of death:

How would you describe your relationship with your mother when growing up? _____

Now (if applicable)? _____

How would you describe your relationship with your father when growing up? _____

Now (if applicable)? _____

Patient Name: _____ **Account:** _____ **Page 7 of 10**

SIBLINGS: Please list ALL siblings (If step or half, indicate the parents you have in common by M=Mother, F=Father, SM=Stepmother, SF=Stepfather; if deceased, write D by name and age died):

Name _____ Age _____ (Half or Step? Parents) _____ Did they live with you? _____ Describe your relationship. _____

EDUCATION: Highest Level of Education: _____ Did you receive Special Education Services in school? _____ If yes, please explain. _____

Are you currently enrolled in school? _____ If yes, where? _____

What is your Major/course of study? _____

When will you be finished? _____

MILITARY SERVICE: If no military history, check here:

Branch: _____ Dates Served: _____

Discharge Rank: _____ Type of Discharge: _____

Did you sustain physical or psychological injuries in the Military? _____ If yes, please explain: _____

EMPLOYMENT: Please list your work history (beginning with your current/most recent job):

Employer	Position Held	Hrs/Wk	Dates	Reason Left
----------	---------------	--------	-------	-------------

Are you Unemployed? _____ Seasonally? _____ Are you receiving Unemployment? _____

Are you on **SICK/MEDICAL LEAVE**? _____ **LONG TERM DISABILITY**? _____

WORKERS' COMPENSATION? _____ **SOCIAL SECURITY DISABILITY**? _____ **SSI**? _____

Are you awaiting resolution of a claim for any of the above? _____ If yes, please explain and give your Attorney's name (if applicable): _____

Have you had any **LEGAL PROBLEMS**, past or present? _____ If yes, please explain (dates/offenses/incarcerations/current status): _____

Were you raised in a **RELIGION / FAITH / SPIRITUAL TRADITION**? _____ If yes, which one/ones? _____ Do you currently participate in

a church or faith group? _____ If yes, where? _____

Is religion/faith/spirituality a meaningful part of your private life? _____ Please explain (if you are comfortable doing so): _____

Do you have an **ETHNIC HERITAGE** that is an influence on your life? _____ If yes, please explain: _____

What do you consider to be your **STRENGTHS** that will help you in treatment? _____

What **COPING SKILLS** have you used in the past? _____

Who would you say are the most **SUPPORTIVE PEOPLE** in your life? _____

Will anyone else be involved in your treatment? ____ If yes, who and to what extent? _____

MEDICAL HISTORY

PRIMARY CARE PROVIDER: _____

Address: _____

Phone: _____ Fax: _____

When was your last visit? _____ Last physical exam with bloodwork? _____

Are there other physicians/specialists you see on a regular basis? _____

CHECK IF YOU HAVE EVER HAD:

Loss of Consciousness Head Injury Seizures

CHECK IF YOU HAVE ANY OF THE FOLLOWING:

- | | |
|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> IBS/Crohn's Disease/Celiac Disease |
| <input type="checkbox"/> Anemia/ Low Iron | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Chronic Back or Neck Pain | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Chronic Nosebleeds | <input type="checkbox"/> Paralysis/ Loss of Sensation |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Parkinson Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin Conditions/Eczema/Dermatitis |
| <input type="checkbox"/> GERD (Acid Reflux)/Ulcers | <input type="checkbox"/> Stroke/ TIA |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Vision |

Patient Name: _____ **Account:** _____ **Page 9 of 10**

Cancer

If yes for cancer, what type and what treatment (if applicable)? _____

Surgeries

If yes for surgeries, what type? _____

Do you have any other medical problems not listed above? If so, please list here: _____

CURRENT NON-PSYCHIATRIC MEDICATIONS: (if more than 6, please attach a separate list)

Name	Dosage	Duration	Response

Do you take these medications as prescribed? _____ If not, please explain: _____

DRUG ALLERGIES AND REACTIONS: _____

Signature: _____ **Date:** _____

If someone other than the patient completed or helped complete this form:

Signature: _____ **Date:** _____

(Please Circle: Spouse/Guardian/Legal Representative/Other _____)