CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

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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

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

BIPOLAR DISORDER

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

POSTTRAUMATIC STRESS DISORDER

- ☐ Traumatic Memories
- ☐ Distressed at Reminders
- ☐ Easily Startled / Aroused
- ☐ Avoids Reminders
- ☐ Frequent Nightmares
- ☐ Flashbacks
- ☐ Emotional Numbness
- ☐ Can't Remember Event

ANXIETY

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

SOCIAL ANXIETY

☐ Shy/Timid
☐ Avoiding Crowds
☐ Avoiding Public Places
☐ Self-conscious
☐ Dislike Attention on You
☐ Feeling Judged by Others

OBSESSIVE COMPULSIVE DISORDER

☐ Obsessive Thoughts
☐ Repetitive Thoughts
☐ Compulsive Hand Washing
☐ Compulsive Counting
☐ Compulsive "Checking"
☐ Compulsive Neatness

ATTENTION/HYPERACTIVITY PROBLEMS

☐ Distractible
☐ Poor Concentration
☐ Many Unfinished Tasks
☐ Hyperactive
☐ Impulsive
☐ Procrastinates
☐ Forgetful
☐ Misplaces Things
☐ Indecisive
☐ Can't Sit Still
☐ Leaves Seat
☐ Interrupts Others

BEHAVIORAL PROBLEMS

☐ Physical Aggression
☐ Extreme Anger or Rage
☐ Verbal Altercations
☐ Destroying Property
☐ Throwing Things
☐ Fire Setting
☐ Hurting Animals

EATING DISORDERS

☐ Fear of Weight Gain
☐ Binging/Purging
☐ Distorted Body Image
☐ Excessive Exercising
☐ Excessive Dieting
☐ Excessive Overeating

DISSOCIATION

☐ Feeling Outside Your Body
☐ Things Feel "Not Real"
☐ Time Elapsed, No Memory
☐ Gaps in Knowledge

PSYCHOSIS

☐ Hearing Voices Others Don't
☐ Seeing Things Others Don't
☐ Paranoia
☐ Delusions

AUTISM SPECTRUM DISORDER

☐ Socially Unconnected/Awkward
☐ Avoids Eye Contact
☐ Language Impairments
☐ Rigidity/Inflexibility
☐ Unusual Repetitive Behaviors
☐ 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 <u>your</u> 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		☐	☐	
Nicotine		☐	☐	
Alcohol		☐	☐	
Marijuana		☐	☐	
Inhalants		☐	☐	
Hallucinogens (LSD/Ecstasy/PCP/Mushrooms)		☐	☐	
Opiates (Heroin/Morphine/Other Narcotics)		☐	☐	
Sedatives		☐	☐	
Steroids		☐	☐	
Stimulants (Meth/Crack/Cocaine/Crank)		☐	☐	
Synthetic Drugs/Bath Salts		☐	☐	
Misuse of Other Prescription Drugs		☐	☐	

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)?_____

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:

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

☐ 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_____)