**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Adult Intake Form**

**PRESENTING PROBLEMS AND CONCERNS**

Describe the problem that brought you here today:

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

🞎 Distractibility 🞎 Change in appetite 🞎 Suspicion/paranoia 🞎 Hyperactivity

🞎 Lack of motivation 🞎 Racing thoughts 🞎 Impulsivity 🞎 Social Withdrawal

🞎 Excessive energy 🞎 Boredom 🞎 Anxiety/worry 🞎 Wide mood swings

🞎 Poor memory 🞎 Confusion 🞎 Panic attacks 🞎 Sleep problems

🞎 Seasonal mood change 🞎 Fear away from home 🞎 Nightmares 🞎 Sadness/depression

🞎 Social discomfort 🞎 Eating problems 🞎Loss of interest/motivation 🞎 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 🞎 Increased Alcohol use 🞎 Drug use/abuse 🞎 Fatigue

🞎 Visual hallucinations 🞎 Recurring, disturbing memories

Other:

**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 🞎 Physical Health 🞎 Spiritual/Religious life

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

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

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

Have you gambled, begun using alcohol/increased alcohol use, or begun using drugs/increased drug use in the past 6 months? 🞎 Yes 🞎 No If yes, please describe:

**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 |  |
| Bipolar Disorder |  |
| Suicide |  |
| Anxiety |  |
| Panic Attacks |  |
| Obsessive Compulsive |  |
| Anger/Abusive Behavior |  |
| Schizophrenia |  |
| Eating Disorder |  |
| Alcohol Abuse/Addiction |  |
| Drug Abuse/Addiction |  |

🞎 Parents legally married or living together 🞎 Mother remarried: Number of times:

🞎 Parents temporarily separated 🞎 Father remarried: Number of times:

🞎 Parents divorced or permanently separated

Who do you live with? Name Age Relationship

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**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

**PREVIOUS MENTAL HEALTH TREATMENT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes | No | Type of Treatment | When? | Provider/Program | Reason for Treatment/Outcome |
|  |  | Outpatient Counseling |  |  |  |
|  |  | Medication (mental health) |  |  |  |
|  |  | Psychiatric Hospitalization |  |  |  |
|  |  | Drug/Alcohol Treatment |  |  |  |
|  |  | Self-Help/Support Groups |  |  |  |

**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/Opiates |  |  |  |  |  |  |  |  |
| PCP/LSD |  |  |  |  |  |  |  |  |
| Steroids |  |  |  |  |  |  |  |  |
| Tranquilizers/Sleep Aids |  |  |  |  |  |  |  |  |
| Benzodiazepines |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |

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

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

**MEDICAL INFORMATION**

Date of last physical exam: Have you ever experienced any of the following medical conditions?

🞎 Asthma 🞎 Headaches 🞎 Stomach aches 🞎 Chronic pain

🞎 Surgery 🞎 Serious accident 🞎 Head injury 🞎 Dizziness/fainting 🞎 Seizures 🞎 Vision problems 🞎 Diabetes 🞎 Hearing problems

🞎 Miscarriage 🞎 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 or foods: 🞎 None

If yes, please list:

**SIGNIFICANT FAMILY MEDICAL HISTORY (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 group

If you are experiencing any difficulties in your support network, please describe:

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

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

Please describe your strengths, skills, and talents?

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

**MISCELLANEOUS INFORMATION**

**Employment**

Employer: Position:

Length of time in this position: Job Duties:

Stress level of this position: 🞎 Low 🞎 Medium 🞎 High

If you are experiencing any difficulties with work, or feel that your work is contributing to your current mental health concerns, please describe:

**Education**

Are you currently attending school? 🞎 Yes 🞎 No

High School Graduate? 🞎 Yes 🞎 No Year: GED? 🞎 Yes 🞎 No Year:

Did you attend college? 🞎 Yes 🞎 No Course of Study: Did you graduate? 🞎 Yes 🞎 No Year: 🞎 Associate’s 🞎 Bachelor’s 🞎 Graduate 🞎 Doctoral/Professional

Do you have any desire or interest in returning to school? 🞎 Yes 🞎 No

**Military Service**

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

Branch: Date of Discharge: Type of Discharge: Rank:

Were you in combat? 🞎 Yes 🞎 No

If you feel that your military experiences caused or contribute to your current mental health concerns, please describe:

**Legal**

Are you currently involved in any legal issues (pending cases, recent charges/arrests, probation, drug court, DUI, domestic violence, etc.?) 🞎 Yes 🞎 No If yes, please describe:

Are you currently involved in any divorce or child custody proceedings? 🞎 Yes 🞎 No If yes, please explain: