**Intake form - Adults**

**Note: This information is confidential.**

**Demographic Information:**

|  |  |
| --- | --- |
| Name: | Date: |
| Date of Birth: | Gender:  Preferred pronouns: |
| Home/Mobile Phone: | Is it ok to leave a message for you at this number? Y / N |
| Work Phone: | Is it ok to leave a message for you at this number? Y / N |
| Email: | Is it ok to email you? Y / N |
| Street Address: | City: Zip: |
| Relationship Status: | Number of Dependents: |
| Current Occupational Status: (i.e., F/T, P/T, self-employed, student, not working): | |
| Current Employer: | Position Title: |
| Emergency Contact Name: | Emergency Contact Phone & email: |
| Emergency Contact Relationship: | How were you referred? |
| Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary holder name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Policy Number:  DOB: \_\_\_\_\_\_\_ |

**Current Concerns:**

**What concern brings you in?**

**When did this concern begin? (Please attempt to use dates.)**

**Have you been in therapy before or received any prior professional assistance for your mental well-being? If so, please give dates and indicate what was helpful to you, and what was NOT helpful in that process:**

**What are major events in your life that you would like me to be aware of?**

**What do you hope to accomplish in Therapy?**

**Strengths:**

Whom do you go to for support? (Check all that apply):

|  |  |  |
| --- | --- | --- |
| * Family | * Pets | * Community Support groups |
| * Partner | * Religious/Spiritual community | * Online group |
| * Friends | * Professional Caregiver | * Other: |

Please rate how much support you have overall in your life:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 |
| A Lot | Some | Limited | Very Little | None |

**Are there any cultural, religious, spiritual, or ethnic factors that you would like me to be aware of? If yes, please describe:**

**What do you enjoy doing in your free time, either on your own or with others?**

**What accomplishments do you feel proud of?**

**Physical Health:**

**What do you do to keep yourself healthy? (i.e., exercise, sleep, diet, meditation, etc.):**

**Do you have any current concerns about your physical health? Please specify:**

**Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):**

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_ Prescribed By:\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_ Prescribed By:\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_ Prescribed By:\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_

### Physical Symptoms– Check any of the following symptoms that apply to you:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Headaches | * Stomach issues | * Skin problems | * Dizziness | * Tics |
| * Dry mouth | * Palpitations | * Fatigue | * Burning /itchy skin | * Muscle spasms |
| * Twitches | * Chest pains | * Tension | * Back pain | * Rapid heart beat |
| * Sexual disturbances | * Tremors | * Unable to relax | * Fainting spells | * Blackouts |
| * Bowel disturbances | * Use Laxatives | * Excessive sweating | * Tingling | * Watery eyes |
| * Visual disturbances | * Numbness | * Flushes | * Hearing problems | * Don’t like being   Touched |
| * Poor appetite | * Binge/Purge | * Constipation | * Allergies | * Nausea |

### Substance Use

Please share information about the substances that you have used within the past year. Include street drugs, misuse of prescription medication, and use of medication not prescribed to you:

|  |  |  |  |
| --- | --- | --- | --- |
| Substance | How much and how often | When last used? | Age you started using? |
| Caffeine |  |  |  |
| Tobacco |  |  |  |
| Marijuana/pot |  |  |  |
| Cocaine/crack |  |  |  |
| Other opiates/narcotics (i.e. pain killers) |  |  |  |
| Barbiturates (downers) sedatives/tranquilizers |  |  |  |
| Amphetamines/stimulants |  |  |  |
| Hallucinogens/LSD/Psychedelics |  |  |  |
| Other: |  |  |  |

### Mental Health history:

**Have you been diagnosed in the past? Yes No**

|  |  |  |
| --- | --- | --- |
| **Who diagnosed?** | **Age at diagnosis** | **Diagnosis:** |
|  |  |  |
|  |  |  |
|  |  |  |

**Have you ever been hospitalized for psychiatric reasons? If yes, please provide dates and reason for hospitalization:**

**Have you ever attempted suicide? If yes, when was your most recent attempt?**

**Do you do things that other people might think are impulsive, risky, or dangerous? If yes, please describe:**

**Has anyone in your family or anyone close to you committed or attempted to commit suicide? If yes, relationship to you:**

**Do you have a history of abuse of any kind (sexual, physical, or verbal)?**

* Yes
* No
* Uncertain

|  |  |  |  |
| --- | --- | --- | --- |
| Has you been exposed to: | Y | N | Please explain |
| Death of close or significant person? |  |  |  |
| Illness of yourself or another significant person? |  |  |  |
| Hospitalization of yourself or a significant other? |  |  |  |
| Accident that you or a significant other was involved in or witnessed? |  |  |  |
| Long separation from significant others? |  |  |  |
| Divorce? |  |  |  |
| Sexual hurt? |  |  |  |
| Witnessing fight or violence in the family? (Outburst, cursing, hitting) |  |  |  |
| Threats for leaving or hurting? |  |  |  |
| Other events that might influence you? |  |  |  |

**Many people have the following experiences. Please check any of these that you believe you experience more than other adults:**

|  |  |
| --- | --- |
| * Difficulty focusing or prioritizing | * Irritable |
| * Overactive/restless | * Nightmares |
| * Do or say things without thinking about the consequences | * Can’t stop thinking about a past experience |
| * Hot temper | * Anxious |
| * Bad memory | * Preoccupied with my body weight or shape |
| * Feel that people are conspiring against me | * Do things that are harmful to myself or others |
| * Hear or see things that other people don’t hear or see | * Chronic relationship problems |
| * Feel hopeless | * Difficulty telling the truth |
| * Thinking about suicide | * Getting into physical fights |
| * Weight loss/gain | * Stressful home conditions |
| * Intense highs and lows with my mood | * Experiences that I do not understand |
| * Can’t slow down my thinking | * Homicidal thoughts |
| * Panicky | * Overly dependent on others |
| * Extreme fear of a specific object, activity, or situation | * Lack of motivation |
| * Going out of my way to avoid things that I fear | * Working too hard |
| * Worry about what others might think of me | * Crying/tearful |
| * Feel driven to do things over and over | * Eating problems (i.e., not eating, binging, etc.) |
| * Frequent, unwanted thoughts or images | * Drinking or using drugs |

**Relationships:**

**Please share briefly about the relationships within your family of origin.**

**Please share briefly about your current family (if different from family of origin) and the relationships you have with them.**

**Who are the people you would consider closest to you in the present?**

**Please describe the nature of these relationships and the role you play in them.**

**How do you handle conflict or problem solve when someone is emotionally distressed currently in these relationships?**

**Please describe your social relationships with peers in the present.**

**Presently, what level of relationship is hardest for you (i.e. people who are close to me, people I am friendly with, acquaintances, colleagues etc.)?**

**If there is any other information, you’d like to share with me on this form that was not covered in the questions above, please take the space below to do so.**

**Current provider’s information:**

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN/ NP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation: \_\_\_\_\_\_\_\_\_\_\_\_\_

phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list previous therapeutic services that you as a family, or your child have received

Name of profession Dates Reason

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