Adult Intake Form

Date: ____________

Identifying Data

Name: ______________________________ **Birthdate:** ____________ **Age:** ________

Emergency contact and phone number: ______________________________

Reason for visit: ______________________________

Referred by: ______________________________

Education and work history

Education level: __________ **Degree(s) earned:** ____________ **Major course of study:** ______________

Current occupation ______________________ **Employer:** ______________________

Family and social history

Spouse/partner's name: ______________________ **Age:** _____ **Occupation:** ______________

Dates of marriages, separations, divorces (if applicable):

____

Names of children:	Age:	Gender:	Grade:
________________________	_____	________	________
________________________	_____	________	________
________________________	_____	________	________
________________________	_____	________	________

Involvement in social services, child protection or court system?

____

Religious/spiritual practices/affiliations: ______________________________

Family history of mental health:

___ Attentional Problems ___Alcohol/drug abuse ___Anxiety ___Bi-Polar Disorder

___Depression ___ Domestic Violence ___Eating Disorder ___Obsessive Compulsive Disorder ___Phobias

___Panic Disorder ___ Schizophrenia/Psychosis ___Suicide Attempts or completion

Physical, sexual or emotional abuse in past: ☐ yes ☐no **If so, what type?** ______________________

Health Information

Primary care clinic location/ Physician name: ______________________________

Date of last medical exam: ____________ Current physical condition: ___poor ____ Fair ____Good ____Excellent

Current medical conditions: ______________________________

List hospitalizations/surgeries/conditions: ______________________________

Current medications: ______________________________

List drug allergies: ______________________________

Previous counseling, treatment or hospitalizations for mental health or chemical dependency issues:

____

Do you consume alcohol? □ yes □ no How often and amount? ______________________________

Any use of recreational drugs currently or in history? □ yes □ no If so, type and frequency: ____________

Have you ever felt like you should reduce your use? □ yes □ no

Have people criticized your use? □ yes □ no

Have you ever felt bad or guilty about your use? □ yes □ no

Have you ever had alcohol or drugs first thing in the morning to steady your nerves or to get rid of a hangover? □ yes □ no

Please check all symptoms that have occurred over the past month:

□ Depressed mood
□ Thoughts to harm self
□ Hopelessness
□ Irritability
□ Low motivation/less interest in things
□ Isolative/withdrawn from others
□ More tired than usual
□ Avoidance of people or tasks
□ Excitability/Excessive energy
□ Feeling overwhelmed
□ Problems concentrating/focusing
□ Regressive behaviors
□ Ruminating thoughts
□ Rapid speech
□ Hearing voices
□ Panicky feeling
□ Tenseness
□ Mood swings
□ Destroying property
□ Nightmares
□ Disregard for others
□ Impulsivity
□ Thoughts to harm others
□ Self injury

Other concerns: ______________________________

Goals for therapy

Describe areas in your life and skills you would like to improve or develop: ______________________________

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