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 Dependants:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, not working):	
Current Employer:	Position Title:
Emergency Contact Name:	Emergency Contact Phone:
Emergency Contact Relationship:	How were you referred?
Insurance: _____ Primary holder name _____	Policy Number: DOB: _____

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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:

What do you hope to accomplish in counseling?

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Strengths:

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

- ☐ Family
- ☐ Partner
- ☐ Friends
- ☐ Pets
- ☐ Religious/Spiritual community
- ☐ Professional Caregiver
- ☐ Community Support groups
- ☐ Online group
- ☐ 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?

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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:

Do you have a physical/medical health provider? If yes, what is his or her name?

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:_____

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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:			

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Mental Health history:

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

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

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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 dependant 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

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.

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Current provider's information:

Primary Care Provider: _____ phone: _____

Email Address: _____

Psychiatrist: _____ phone: _____

Email Address: _____

RN: _____ 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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