CLIENT NAME: DATE:

ADULT INTAKE FORM

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

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

Distractibility	Change in appetite	No/few friends	Manipulative Behavior
Hyperactivity	Withdrawal from People	Defiance	Visual Hallucinations
Impulsivity	Anxiety/worry	Aggression/fights	Eating problems
Boredom	Panic attacks	Homicidal thoughts	Sleep problems
Nightmares	Frequent arguments	Fear away from home	Poor memory/confusion
Social discomfort	Toileting problems	Sadness/depression	Irritability/anger
Hopelessness	Phobias	Fire setting	Peer/sibling conflict
Stealing	Obsessive thoughts	Thoughts of death	Work/school problems
Legal problems	Destroys property	Compulsive behavior	Self-harm behaviors
Crying spells	Racing thoughts	Running away	Sexual behavior
Loneliness	Swearing	Computer addiction	Wide mood swings
Low self worth	Suspicion/paranoia	Curfew Violations	Alcohol/drug use
Fatigue	Hearing voices	Lying	Lack of motivation
Recurring, disturbing memories		Other:_____	

Are your problems affecting any of the following?

Self esteem	Handling everyday tasks	Relationshiops	Hygiene	Health
Work/school	Recreational activities	Legal matters	Housing	Finance

CLIENT NAME: DATE:

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 in the past 6 months? If yes, please let us know the following: □ Yes □ No

Have you ever felt the need to bet more and more money? □ Yes □ No

Have you ever had to lie to people about how much you gambled? □ Yes □ No

FAMILY AND DEVELOPMENTAL HISTORY

RELATIONSHIP	NAME	LIVES WITH YOU?	AGE	QUALITY OF RELATIONSHIP
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Spouse/Partner				
Children				

FAMILY MENTAL HEALTH PROBLEMS?	WHO?
Hyperactivity	
Sexually Abused	

CLIENT NAME: DATE:

Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

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

□ Parents temporarily separated Father remairried: Number of times: _____

□ Parents divorced or permanently separated

CLIENT NAME: DATE:

Please **circle** 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 Homelessness Multiple family moves Physical abuse

Teen pregnancy Parent illness Parent substance abuse Crime victim

Financial problems Loss of a loved one Placed a child for adoption

PREVIOUS MENTAL HEALTH TREATMENT

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

SUBSTANCE USE HISTORY

Please **circle** those that you either currently use (last 6 months) or have a history of past use:

Tobacco □Current □Past frequency/amount: _____

Caffeine □Current □Past frequency/amount: _____

Alcoho □Current □Past frequency/amount: _____

Marihuana □Current □Past frequency/amount: _____

Cocaine/Crack □Current □Past frequency/amount: _____

Ecstacy □Current □Past frequency/amount: _____

Heroin □Current □Past frequency/amount: _____

Inhalants □Current □Past frequency/amount: _____

Pain Killers □Current □Past frequency/amount: _____

PCP/LSD □Current □Past frequency/amount: _____

Steroids □Current □Past frequency/amount: _____

CLIENT NAME: DATE:

Tranquilizers □Current □Past frequency/amount: _____

Methamphetamines □Current □Past frequency/amount: _____

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?

If yes, please describe: _____ □ Yes □No

CLIENT NAME: DATE:

MEDICAL INFORMATION

Date of your last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime? Please **circle**

Allergies	Asthma	Headaches	Stomach aches	Chronic pain	Surgery
Head Injury	High fevers	Diabetes	Serious accident	Vision problems	Seizures
Abortion	Meningitis	Miscarriage	Sleep Disorder	Hearing problems	STD's

Please list any CURRENT health concerns: _____

Who is your primary care physician? _____

Current medications **both prescription and over the counter** (including vitamins, herbs, etc.): □ None

Medication	Dosage	Date First Prescribed	Prescribed By

Allergies and/or adverse reactions to medications? If yes, please list: _____

_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (**circle** all that apply)

Family Neighbors Friends Students Co-Workers

Community Group Religious/Spiritual Center Other: _____

To which cultural/ethnic group do you belong or identify with? _____

Are you experiencing any difficulties due to cultural or ethnic issues? If yes, please describe: _____

_____

CLIENT NAME: DATE:

How important are spiritual matters to you? □Not at all □Little □Somewhat □Very Much

Please describe your strengths, skills and tallents : _____

_____

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

_____

MISCELLANEOUS INFORMATION

Employment

Employer: _____ Position: _____

Length of time in this position: _____ Stress Level: **High** **Medium** **Low**

Education

Are you currently attending school? □ Yes □No Highest level of education? (please **circle)**

High school graduate GED Associates Degree Undergraduate Degree Graduate Degree

Military Service

Have you been or are you currently in the military? □ Yes □No

Branch_____ Date of Discharge_____

Type of Discharge_____ Rank_____

Have you ever been in combat? □ Yes □No

Legal

CLIENT NAME: DATE:

Have you ever been convicted of a midemeanor or felony? □ Yes □No

If yes, please explain: _____

_____

Are you currently involved in any divorce or child custody proceedings? □ Yes □No

If yes, please explain: _____

_____

Therapists Notes: Initial: _____