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Adult Intake Form

PERSONAL INFORMATION

Client Name:		**Date:**
Address:		**City:** **Zip:**
Home Phone with area code:	**Work Phone with area code:**	**Cell Phone with area code:**
Can we leave a confidential message at: **Home:** Yes ☐ No ☐	**Work:** Yes ☐ No ☐	**Cell:** Yes ☐ No ☐
Age: **Date of Birth:**		**Birth Certificate:** **Male** ☐ **Female** ☐ **Identify As:** **Male** ☐ **Female** ☐ **Non-binary** ☐
Ethnicity/Race:	**Primary Language:**	**Referred By:**
Marital Status:		
Employer:	**Occupation:**	
E-mail Address:		
How did you hear about us: ☐ Psychology Today Website ☐ Internet Search ☐ Physician _____ ☐ Friend ☐ Movie Ad ☐ Other_____		

IN CASE OF EMERGENCY

Contact Name:	**Phone Number with area code:**
Relationship to You:	**Can we leave a confidential message with this person:** **Yes** ☐ **No** ☐

FAMILY INFORMATION

NAMES	M/F	AGE	BIRTH DATE	EDUCATION	OCCUPATION
Self:					
Spouse/Partner:					
CHILDREN/STEPCHILDREN	**M/F**	**AGE**	**BIRTH DATE**	**WHO DO THEY LIVE WITH?**	**SPECIAL NEEDS?**
1.					
2.					
3.					
4.					
5.					
6.					

What brings you in today? Briefly describe your situation.

_____

_____

_____

How long has this been occurring?

_____

What do you think caused it?

_____

_____

Have you tried anything to change this? Describe what you have tried.

_____

_____

Who lives with you in your home?

_____

Are you currently in a relationship?

Yes ☐ No ☐

If yes, how would you describe your current relationship?

Please check √ the box if the following have caused SIGNIFICANT (interferes with your day-to-day life) distress:

Ever in Your Life	Last 2 weeks		Ever in Your life	Last 2 weeks	
		School problems			Legal problems
		Financial problems			Relationship problems
		Childhood issues			Memory problems
		Career problems			Sexual concerns
		Sadness			Don't need much sleep
		Lack of enjoyment in activities			Racing thoughts
		Difficulty starting anything			Short attention span
		Change in appetite (increase or decrease)			Talking a lot (more than usual)
		Weight loss or gain			Feeling on top of the world
		Sleep problems (too much or too little)			Irritability
		Fatigue/Feeling tired			Worried
		Feelings of worthlessness			Jittery/Jumpy/Restless
		Guilt			Increased muscle tension
		Difficulty focusing/Distracted easily			Heart racing/Chest pain
		Loss of interest in others			Trembling/Shaking
		Difficulties in making decisions			Shortness of breath/Feeling smothered
		Thoughts of hurting self			Choking sensation
		Suicidal thoughts			Nausea
		Urge to hurt someone else			Dizzy/Faint/Lightheaded
		Hopelessness			Feeling detached from self/unreal
		Eating out of control			Fear of losing control/Going crazy
		Uncontrolled recurring thoughts			Fear of dying
		Flashbacks (re-experience past event)			Numbness or tingling
		Traumatic event			Chills or hot flashes
		Recent loss			Avoiding public places
		Concern about weight			Concern others are watching/judging you
		See or hear things others don't			Unusual thoughts or ideas
		Intentionally skipping meals			Urges to repeat behaviors

SUBSTANCE USE: Please indicate your usage of the following substances

Substance	Currently Use	Used In the Past	Date of Last Use	Average Use
Caffeine(Coffee/tea/soda)				
Tobacco				
Alcohol				
Marijuana				
Prescription Drugs (Xanax, Anxiolytics, Valium)				
Inhalants				
Hallucinogens (LSD/Ecstasy/PCP/mushrooms)				
Steroids				
Stimulants (Meth/Crack/Cocaine/Crank)				
Opioids (Heroin, Codeine)				
Other:				

In the **past 12 months**, has your substance use **repeatedly** caused or contributed to:

Interference with home, work, or school obligations Yes ☐ No ☐
Risk of bodily injury (drinking/using and driving, operating machinery, swimming) Yes ☐ No ☐
Run-ins with the law (arrests or legal problems) Yes ☐ No ☐
Relationship trouble/problems (family, intimate partners, friends) Yes ☐ No ☐

In the **past 12 months**, have you:

Needed to use substances a lot more to get the same effect Yes ☐ No ☐
Shown signs of withdrawal (tremors, sweating, nausea, or insomnia when trying to quit or cut down) Yes ☐ No ☐
Not been able to stick to limits you set for yourself (with substances) Yes ☐ No ☐
Not been able to cut down or stop using substances Yes ☐ No ☐
Spent a lot of time using, thinking about using, or recovering from using Yes ☐ No ☐
Spent less time on other activities that had been important or pleasurable in the past Yes ☐ No ☐
Kept using substances despite problems (financial, work, family, friends) Yes ☐ No ☐

Have you ever been treated for any substance use problem/issue? Yes ☐ No ☐

Where	When	What Substance(s)

PSYCHOLOGICAL TREATMENT HISTORY

List prior treatment by a psychologist, therapist, counselor for personal, relationship, or familial problems:

Who did you see	When	Reason

Have you ever been hospitalized for any mental health reason: Yes ☐ No ☐

Where	When	Reason

RISK ASSESSMENT

Have you ever tried to kill yourself: Yes ☐ No ☐

If yes, How: _____

How many times: _____ Date(s): _____

Were you using any substances: Yes ☐ No ☐ If yes, Kind: _____

Have you ever tried to hurt yourself: Yes ☐ No ☐

If yes, How: _____

How many times: _____ Date(s): _____

Were you using any substances: Yes ☐ No ☐ If yes, Kind: _____

Have you ever thought of hurting/killing yourself: Yes ☐ No ☐

If yes, How: _____

How many times: _____ Date(s): _____

Were you using any substances: Yes ☐ No ☐ If yes, Kind: _____

Are you thinking about hurting/killing yourself now: Yes ☐ No ☐

If yes, How: _____

Do you currently have any of the following thoughts:

Thoughts of harming anyone?	No ☐ Yes ☐ Who:
Have you ever tried to hurt someone?	No ☐ Yes ☐ Who:
Have you ever gotten into trouble because of a temper or violence?	No ☐ Yes ☐
Does drinking/using ever lead to you becoming violent towards others?	No ☐ Yes ☐
Do you have access to a gun or weapon?	No ☐ Yes ☐ Kind of Weapon:
Have you ever considered doing harm to others with this weapon?	N/A ☐ No ☐ Yes ☐
Have you ever considered doing harm to yourself with this weapon?	N/A ☐ No ☐ Yes ☐
Have you threatened anyone within the last 6 months?	No ☐ Yes ☐ Who:
Have you assaulted anyone within the last 6 months?	No ☐ Yes ☐ Who:

TRAUMA

Have you ever experienced any kind of sexual assault, rape, or molestation as a child or adult? Yes ☐ No ☐

If yes, how old were you? _____

Did you know the person who hurt you? _____

Any issues/problems because of this? _____

Please list any other fearful/distressing/traumatic childhood or adult event:

_____

_____

_____

DAILY LIVING

Do you have a religious affiliation: Yes ☐ No ☐ Do you currently practice: Yes ☐ No ☐

Are you spiritual: Yes ☐ No ☐

On a scale of 1 to 10, how important is your spiritual/religious beliefs:

Not at all important — Somewhat important — Very important

1 3 5 7 10

What are your current hobbies, interests, or ways you spend your free time:

_____

Have you changed your level of involvement in any of these activities: Yes ☐ No ☐

Do you exercise on a regular basis: Yes ☐ No ☐

If yes, what do you do: _____

How do you deal with stressful situations: _____

What is your greatest strength (what do you do best/what are you most proud of):

_____

OTHER

Is there anything else that is important for me to know that is not listed on this form:

_____

_____

_____