ADULT INTAKE FORM

Please provide the following information and bring it to your first session. Note: The information you provide is confidential and is for the purpose of assessment and initiating therapy sessions:

Full Name: _____

Name you wish to be called: _____

Birth Date:_____Age:_____Gender: ____Male ____Female ____Other

Marital Status: ___Never Married ___Domestic Partnership ___Married ___Separated ___Divorced ___Widowed

Do you have any children
(names/ages)?_____

Your Mailing Address: _____

Primary Phone: ( ) _____ Other Phone ( ) _____
Is it okay to leave a message? _____

Emergency Contact(s): _____ Permission to call in emergency?

____Yes ____No Phone number for emergency contact _____

Referred by anyone? _____

Are you taking any medications? ____Yes ____No If yes, please list:
_____

Have you ever been prescribed psychiatric medication? ____ Yes ____No If yes, please list:

_____ Have you ever received any type of mental health support? ____Yes ____No If yes, please list previous provider(s): _____

HEALTH INFORMATION

1. Please circle how you rate your current physical health:
Poor Unsatisfactory Satisfactory Good Very Good

Please list any health problems you are experiencing: _____

_____**ANY ALLERGIES?**_____

2. Please circle how you rate your current sleep habits:
Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are experiencing: _____

_____

3. Please describe your level of exercise (how often, types of exercise, etc):

_____

4. Please list any difficulties you experience with appetite/eating patterns:

_____

5. Are you experiencing sadness, emptiness, grief or depression? ____Yes ____No
If yes, how long? _____

6. Are you experiencing anxiety, panic attacks or phobias? ____Yes ____No
If yes, how long? _____

7. Are you experiencing chronic pain? ____Yes ____No If yes, how long and please describe: _____

8. Please describe alcohol, cigarette, drug usage: _____

10. Briefly describe chronologically, to the best of your knowledge, any trauma history. Trauma may include natural disaster, accident, domestic violence, abuse, neglect, separation from others via death/divorce/cps involvement, etc; witness of scary event, or any other trauma as perceived by you:

_____

_____

11. Are you hurting yourself (cutting, picking, etc) ____Yes ____No please describe:

12. Are you considering harm of self or others (suicide or homicide)? ___Yes ___No
If yes, do you have a plan? _____

13. Do you have firearms in your home? ___Yes ___No If yes, how do you store them? (hiding place, locked away, with/without ammo)

_____

FAMILY MENTAL HEALTH HISTORY

Below, please mention any of the following that has been a challenge for someone in your close family (including you). Please list which family member(s) has had these challenges and if the person is still living:

Challenge **Self or Family Member(s)**

Alcohol/Substance Abuse _____

Anxiety_____

Depression_____

Domestic Violence_____

Eating Disorder_____

Behavior_____

Self or Other Harm_____

Addiction_____

Psychosis_____

ADHD_____

Other_____

ADDITIONAL INFORMATION

1. Please describe your employment status, title, hours, stressors, etc (including homemakers):

_____

_____

2. If you are in school, please note the school name, grade level and any stressors:

_____

_____

3. Please describe spiritual, religious beliefs, if any, and the role it plays in your life:

_____

_____

4. Please describe your strengths (what you like about yourself, coping skills, etc):

_____

_____

5. Please describe your challenges or things you'd like to change about yourself:

_____

_____

6. Please list what you would like to accomplish while in therapy:

_____

_____

_____