Intake (Adult)

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

FIRST NAME

LAST NAME

TODAY'S DATE MM/DD/YY

/ /

BIRTH DATE MM/DD/YY

/ /

AGE

SEX

GENDER EXPRESSION

HOME ADDRESS

PHONE

MAY I LEAVE A MESSAGE?

YES / NO

EMAIL ADDRESS

EMERGENCY CONTACT

NAME

RELATIONSHIP

PHONE NUMBER

ADDRESS

OCCUPATIONAL INFORMATION

ARE YOU CURRENTLY EMPLOYED?

YES / NO

IF YES, WHO IS YOUR CURRENT EMPLOYER?

IF YES, ARE YOU HAPPY AT YOUR CURRENT EMPLOYER?

PLEASE LIST ANY WORK-RELATED STRESSORS, IF ANY:

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PRESENTING PROBLEM (Be specific: When did it start? How did it affect you?)

CURRENT EVENTS, DIFFICULTIES OR SYMPTOMS THAT BROUGHT YOU IN FOR PSYCHOTHERAPY:

HOW HAVE YOU HANDLED THESE STRESSORS SO FAR?

WHAT ARE THE MAIN GOALS THAT YOU WANT TO ACHIEVE THROUGH COUNSELING?

MARITAL STATUS

- [ ] Single

  DO YOU LIVE WITH YOUR SIGNIFICANT OTHER? IF SO, HOW LONG HAVE YOU?

- [ ] Engaged

  WEDDING DATE MM/DD/YY / /

  LENGTH OF TIME TOGETHER

- [ ] Married

  NUMBER OF YEARS

- [ ] Separated

  HOW LONG

- [ ] Divorced

  DATE MM/DD/YY / /

- [ ] Widowed

  HOW LONG

- [ ] Other

  EXPLAIN

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ON A SCALE OF 1-10, HOW WOULD YOU RATE THE QUALITY OF YOUR CURRENT RELATIONSHIP?

____

EXPLAIN YOUR RELATIONSHIP

____

____

____

CHILDREN

NAME	RELATIONSHIP	AGE	SEX	LIVING AT HOME?
			M / F	YES / NO
			M / F	YES / NO
			M / F	YES / NO
			M / F	YES / NO

WHO HAS CUSTODY OF YOUR CHILDREN?

____

DESCRIBE HOW YOUR HOUSEHOLD FUNCTIONS TODAY:

____

____

____

FAMILY OF ORIGIN

FATHER'S NAME	AGE (IF LIVING)	IF DECEASED, WHEN AND AT WHAT AGE?

MOTHER'S NAME	AGE (IF LIVING)	IF DECEASED, WHEN AND AT WHAT AGE?

ARE YOUR PARENTS MARRIED?

YES / NO

IF DIVORCED, WHEN?

____

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SIBLING'S NAME ______ **AGE (IF LIVING)** ______ **IF DECEASED, WHEN AND AT WHAT AGE?** ______

SIBLING'S NAME ______ **AGE (IF LIVING)** ______ **IF DECEASED, WHEN AND AT WHAT AGE?** ______

SIBLING'S NAME ______ **AGE (IF LIVING)** ______ **IF DECEASED, WHEN AND AT WHAT AGE?** ______

DESCRIBE YOUR FAMILY WHEN YOU WERE GROWING UP:

______

______

IS THERE ANY HISTORY OF ALCOHOL ABUSE, ADDICTION TO ILLEGAL OR PRESCRIPTION DRUGS, OR OTHER SUBSTANCE ABUSE FOR YOURSELF OR OTHERS?

SELF	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
SPOUSE	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
CHILD	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
CHILD	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
CHILD	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
FATHER	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
MOTHER	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
SIBLING	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
SIBLING	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______
SIBLING	YES / NO	**IF YES, HOW LONG?**	______	**WHAT SUBSTANCE?**	______

DO YOU USE ALCOHOL OR DRUGS SOCIALLY?

YES / NO

IF YES, PLEASE LIST RECREATIONAL DRUGS? ______

IF YES, ALCOHOL (# DRINKS DAILY AND WEEKLY)

______

DESCRIBE ANY HISTORY OF TREATMENT (AA, DETOX, INPATIENT, GROUP HOME, CIRCUMSTANCES, AGE, DURATION, ETC.)

______

______

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HAVE YOU EVER EXPERIENCED OR WITNESSED PHYSICAL, EMOTIONAL AND OR SEXUAL ABUSE?

IF YES, PLEASE EXPLAIN

COUNSELING HISTORY, NEEDS AND GOALS

LOCATIONS	WHEN	HOW LONG	HELPFUL?
			YES / NO

PLEASE BRIEFLY EXPLAIN YOUR REASONS FOR SEEKING HELP AT THIS TIME:

WERE YOU REFERRED HERE? YES / NO

BY WHOM?

IS THIS COURT MANDATED? YES / NO

ARE YOU CURRENTLY HAVING SUICIDAL OR HOMICIDAL THOUGHTS? YES / NO IF YES, PLEASE DESCRIBE:

HAS ANYONE RELATED TO YOU ATTEMPTED HOMICIDE OR SUICIDE? YES / NO IF YES, PLEASE DESCRIBE:

DO YOU WORRY ABOUT YOUR SAFETY IN YOUR CURRENT LIVING SITUATION? YES / NO IF YES, PLEASE DESCRIBE:

HAVE YOU EVER STRUCK OR THREATENED PEOPLE, ANIMALS, OR HAVE YOU DAMAGED PROPERTY IN ANGER? YES / NO

IF YES, PLEASE DESCRIBE:

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PREVIOUS HOSPITALIZATION

HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL OR EMOTIONAL PROBLEMS?

YES / NO

IF YES, WHEN? ______________________ FOR HOW LONG? ______________________

WHY WERE YOU HOSPITALIZED? ______________________

NAME OF TREATING PSYCHIATRIST ______________________ PHONE NUMBER ______________________

HAVE YOU EVER ATTEMPTED SUICIDE? IF YES, WHEN? ______________________

YES / NO

PLEASE DESCRIBE THE CIRCUMSTANCES THAT LED TO THAT ATTEMPT.

____

____

HAS ANYONE RELATED TO YOU ATTEMPTED HOMICIDE OR SUICIDE? YES / NO IF YES, PLEASE DESCRIBE:

____

____

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

YES / NO

HAVE YOU EVER TAKEN MEDIATIONS FOR A MENTAL OR EMOTIONAL CONDITION?

YES / NO

MEDICATION NAME	PRESCRIBED FOR	WHEN PRESCRIBED	FOR HOW LONG

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HEALTH AND SOCIAL INFORMATION

HOW IS YOUR PHYSICAL HEALTH AT PRESENT? (PLEASE CIRCLE)

Poor / Unsatisfactory / Satisfactory / Good / Very Good

PLEASE LIST PERSISTENT PHYSICAL SYMPTOMS OR HEALTH CONCERNS (E.G. CHRONIC PAIN, HEADACHES, HYPERTENSION, DIABETES, ETC.):

ARE YOU HAVING ANY PROBLEMS WITH YOUR SLEEP HABITS?

YES / NO

HOW IS YOUR PHYSICAL HEALTH AT PRESENT? (PLEASE CIRCLE)

Sleeping too little / Sleeping too much / Poor quality sleep / Disturbing dreams / Other

HOW MANY TIMES PER WEEK DO YOU EXERCISE?

APPROX. HOW LONG EACH TIME?

ARE YOU HAVING ANY DIFFICULTY WITH APPETITE OR EATING HABITS

YES / NO

IF YES, CHECK WHERE APPLICABLE:

Eating less / Eating more / Binging / Restricting intake

HAVE YOU EXPERIENCED SIGNIFICANT WEIGHT CHANGE IN THE LAST 2 MONTHS?

YES / NO

IN THE LAST YEAR, HAVE YOU EXPERIENCE ANY SIGNIFICANT LIFE CHANGES OR STRESSORS:

RELIGIOUS / SPIRITUAL INFORMATION:

DO YOU CONSIDER YOURSELF TO BE RELIGIOUS?

YES / NO

IF YES, WHAT IS YOUR FAITH?

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IF NO, DO YOU CONSIDER YOURSELF TO BE SPIRITUAL?

YES / NO

IF YES, DESCRIBE

____

____

CURRENT LEVEL OF FUNCTIONING:
Please rate the functioning in these areas using a scale of 0 being not applicable thru 9 being no impairment

	NA	CANNOT FUNCTION		SERIOUS IMPAIRMENT		MODERATE IMPAIRMENT		MILD IMPAIRMENT		NO IMPAIRMENT
Job	0	1	2	3	4	5	6	7	8	9
Marital	0	1	2	3	4	5	6	7	8	9
Family	0	1	2	3	4	5	6	7	8	9
Interpersonal	0	1	2	3	4	5	6	7	8	9

OTHER INFORMATION

WHAT DO YOU CONSIDER TO BE YOUR STRENGTHS?

____

____

WHAT DO YOU LIKE ABOUT YOURSELF?

____

____

WHAT ARE EFFECTIVE COPING STRATEGIES THAT YOU'VE LEARNED?

____

____

WHAT ARE YOUR GOALS FOR THERAPY?

____

____

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WHAT ARE YOUR GOALS FOR THERAPY?

- [ ] Social/outgoing
- [ ] Intelligent
- [ ] Self-Controlled
- [ ] Resourceful
- [ ] Creative
- [ ] Can forgive
- [ ] Can ask for help
- [ ] Can express feelings
- [ ] Stable
- [ ] Secure
- [ ] Faithful
- [ ] Physically active
- [ ] Motivated
- [ ] Happy
- [ ] Confident
- [ ] Assertive
- [ ] Not easily depressed
- [ ] Mostly able to relax
- [ ] Liked by others
- [ ] Patient
- [ ] Respect others
- [ ] Perfectionist
- [ ] Have enough money
- [ ] Can accept love from others
- [ ] Worthwhile / "good enough"
- [ ] Shy / backward
- [ ] Stupid / dumb
- [ ] Shy / backward
- [ ] Impulsive
- [ ] Out of control
- [ ] Unimaginative
- [ ] Full of hate
- [ ] Isolated/loner
- [ ] Bottled up
- [ ] Unstable
- [ ] Insecure
- [ ] Unfaithful
- [ ] Lazy
- [ ] Unmotivated
- [ ] Depressed
- [ ] Passive "pushover"
- [ ] Easily discouraged
- [ ] Tense most of time
- [ ] Not liked by others
- [ ] Impatient/edgy
- [ ] Disrespectful
- [ ] Financially stressed
- [ ] Worthless
- [ ] Unattractive
- [ ] Other: ______________________

____

WHAT ARE YOUR CURRENT SYMPTOMS?

- [ ] Headaches
- [ ] Bowel / stomach
- [ ] No appetite
- [ ] Dizziness
- [ ] Tremors
- [ ] Muscle weakness
- [ ] Fainting spells
- [ ] Shortness of breath
- [ ] Hair / skin problems
- [ ] Jaw pain
- [ ] Reproductive problem
- [ ] Sexual problems
- [ ] Excessive sweating
- [ ] Heart problems
- [ ] Heart races / pounds
- [ ] Nausea
- [ ] Fatigue
- [ ] Sadness
- [ ] Worry
- [ ] Overexcited
- [ ] Agitated
- [ ] Panicky
- [ ] Nervous
- [ ] Empty
- [ ] Grieving
- [ ] Despair
- [ ] Hopelessness
- [ ] Fits of rage
- [ ] Jealousy
- [ ] Moodiness
- [ ] Desire to cry
- [ ] Resentment
- [ ] Frustration
- [ ] Inadequacy
- [ ] Memory problems
- [ ] Paranoia
- [ ] Confusion
- [ ] Repetitive thoughts
- [ ] Racing thoughts
- [ ] Attention problems
- [ ] Thoughts of escape
- [ ] Decision problems
- [ ] Poor judgment
- [ ] Hallucinations
- [ ] Disorganized thinking
- [ ] Using drugs or alcohol more
- [ ] Avoiding loved ones
- [ ] Missing work or school
- [ ] Laugh / cry inappropriately
- [ ] Nervous habits (e.g. bites nails)
- [ ] Losing temper
- [ ] Becoming violent
- [ ] Risky behaviors
- [ ] Grind teeth
- [ ] Less or more sexual contact
- [ ] Less or more sleeping

OTHER SYMPTOMS:

____