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:

_____

RISE CANYON RANCH

Intake (Adult)

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

Intake (Adult)

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? _____

RISE CANYON RANCH

Intake (Adult)

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.)

Intake (Adult)

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:

Intake (Adult)

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 MEDICATIONS FOR A MENTAL OR EMOTIONAL CONDITION?

YES / NO

MEDICATION NAME	PRESCRIBED FOR	WHEN PRESCRIBED	FOR HOW LONG

Intake (Adult)

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? _____

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?

Intake (Adult)

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: