**ADULT INTAKE/ REGISTRATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | | Birth Date: |
| Address: | | | |
| Are you (circle): Single ~ In a Relationship ~ Engaged ~ Married ~ Divorced ~ Remarried ~ Other | | | |
| Do you work inside or outside the home? | | | |
| Employer: | | | |
| What is your job title: | | | |
| What is highest grade achieved? | | | |
| If you hold any certificates or degrees, what are they? | | | |
| ***Provide only the phone numbers that you are okay with me calling and leaving a message:*** | | | |
| Cell: | Home: | | Work: |
| Emergency Contact (name, phone and relationship): | | | |
| ***If you are not the subscriber for your insurance, please provide information so I may bill your insurance:*** | | | |
| Name of Subscriber: | | | Birth Date: |
| Address: | | | |
| Employer: | | | |
| Name of Insurance Co: | | | |
| Member ID: | | Group #: | |
| Toll-free phone # on back of your card for either Behavioral Health or Provider Relations: | | | |
| Copay: | Deductible: | | Coinsurance: |
| Do you need prior authorizations for your care? | | | |
| Leave blank for Office: | | | |

Who lives with you, include pets if there is room?

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Age |
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**Medical Information**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Are you willing to sign a release allowing me to communicate with your doctors? Yes or No***

**List any medical concerns you have including allergies:**

|  |  |  |
| --- | --- | --- |
| Medical issue or diagnosis | Medications or treatment if any | Dr. prescribing or providing care |
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Have you ever been hospitalized for strictly medical needs:

|  |  |  |
| --- | --- | --- |
| Where Hospitalized | For what | When |
|  |  |  |
|  |  |  |
|  |  |  |

**Symptom Assessment**

Please give as accurate account as you can and if you have any questions or concerns, we will discuss in session.

**I AM EXPERIENCING...**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptom** | **Never** | **Seldom** | **Often** | **Always** | **For how long?** |
| Frequent worry or tension |  |  |  |  |  |
| Fear of many things |  |  |  |  |  |
| Discomfort in social situations |  |  |  |  |  |
| Obsessive thoughts or actions |  |  |  |  |  |
| Phobias: unusual fears about specific things |  |  |  |  |  |
| Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations |  |  |  |  |  |
| Recurring, distressing thoughts about a trauma |  |  |  |  |  |
| “Flashbacks” as if reliving the traumatic event |  |  |  |  |  |
| Avoiding people/places associated with trauma |  |  |  |  |  |
| Nightmares about traumatic experience |  |  |  |  |  |
| Decreased interest in pleasurable activities |  |  |  |  |  |
| Social Isolation, Loneliness |  |  |  |  |  |
| Suicidal Thoughts |  |  |  |  |  |
| Grief or Feelings of Loss |  |  |  |  |  |
| Difficulty Sleeping |  |  |  |  |  |
| Memory problems |  |  |  |  |  |
| Normal, daily tasks require more effort |  |  |  |  |  |
| Sad, hopeless about future |  |  |  |  |  |
| Excessive feelings of guilt |  |  |  |  |  |
| Low self-esteem |  |  |  |  |  |
| I am Angry, Irritable, hostile |  |  |  |  |  |
| I feel euphoric, energized and highly optimistic |  |  |  |  |  |
| I have racing thoughts |  |  |  |  |  |
| I need less sleep than usual |  |  |  |  |  |
| I am more talkative then usual |  |  |  |  |  |
| My moods fluctuate: go up & down |  |  |  |  |  |
| I cut myself |  |  |  |  |  |
| I gamble or buy lottery |  |  |  |  |  |
| I use legal mood altering substances |  |  |  |  |  |
| I use illegal mood altering substances (I do not report this) |  |  |  |  |  |
| I restrict my food intake |  |  |  |  |  |
| I throw my food up |  |  |  |  |  |
| I have concerns about my sexual life |  |  |  |  |  |
| Risk-taking behaviors |  |  |  |  |  |
| I have trouble getting or keeping employment. |  |  |  |  |  |
| Hearing voices when alone |  |  |  |  |  |
| Other: |  |  |  |  |  |
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**Personal and Family History**

Have **you** ever been hospitalized for a psychiatric illness or concern? Yes / No

*If so, please include when, where, and for what:*

Has a close relative ever been hospitalized for a psychiatric illness or concern? Yes / No

*If so, please include what relative, when, where, and for what:*

Does anyone in your family have a mental illness or thought to have one but not diagnosed? Yes / No

Details:

Does anyone in your family have a substance abuse problem? Yes / No

Details:

Have you or anyone in your family attempted or committed suicide? Yes / No

Have you ever been arrested? Yes / No

How many times have your moved in last 5 years?

Have you experienced any traumatic events in your life? Yes / No

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | N/A | Cannot  Function | Serious  Problems | Moderate  Problems | Mild  Problems | Feeling  Confident | No  Problems |
| How well are you doing at your job? |  |  |  |  |  |  |  |
| How well are you doing in your significant other relationship? |  |  |  |  |  |  |  |
| How well are you doing in your family relationships? |  |  |  |  |  |  |  |
| How well are you doing with relationships outside of family? |  |  |  |  |  |  |  |
| Please rate your physical health: |  |  |  |  |  |  |  |
| Please rate your general happiness and well-being. |  |  |  |  |  |  |  |

**What are a few of the goals you have for yourself for therapy or how would you like things to be different in your life a year from now?**