ADULT INTAKE/ REGISTRATION

Name:	Birth Date:
Address:	
Are you (circle): Single ~ In a Relationship ~ Engaged ~ Married ~ Divorced ~ Remarried ~ Other Details:	
Do you work inside or outside the home?	
Employer:	
What is your job title:	
What is your 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

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

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:					

Personal History

Have you ever been in therapy before? Yes/No
If yes, when?

Have you ever been hospitalized for a psychiatric illness or concern? Yes / No
If so, please include when, where, and for what:

Have you ever attempted suicide? Yes/ No
Details:

Have you ever been arrested? Yes / No
Details:

How many times have your moved in last 5 years?

Are you a military veteran? Yes/No
Details:

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

Do you drink alcohol? Yes/No
If yes, how often and how much do you drink?

Any current or past substance use/abuse? Yes/No
If yes, what do you use and how often?

What are some activities you enjoy?

Who are some important people in your life?

What are your strengths/skills?

	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?

Family History

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

Has anyone in your family attempted or died by suicide? Yes / No
Details:

Was anyone in your family abusive (physically, verbally, or sexually)? Yes/No
Details:

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

Are/were your parents married? Yes/No
Details:

Do you have siblings? Yes/No
Details: