

# ADULT INTAKE FORM

## GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Your age: \_\_\_\_\_ Date of Birth (DOB): \_\_\_\_\_

Address: \_\_\_\_\_

Spouse or Partner's Name (if applicable): \_\_\_\_\_

Home phone: \_\_\_\_\_ May I leave a message? Yes No

Cell phone: \_\_\_\_\_ May I leave a message? Yes No

Email: \_\_\_\_\_ May I email you? Yes No  
(For appointment scheduling purposes only, as email not considered a confidential medium of communication).

Who referred you to my private practice? Please provide agency/professional's name & tel #:

May I contact the agency/person to thank them for referring you? Yes No Please initial: \_\_\_\_\_

What is the main reason you're seeking help? (Please include how long you've had these symptoms or problems): \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

## HEALTH & MENTAL HEALTH INFORMATION

Do you currently have any medical problems? \_\_\_\_\_

Have you ever been treated for any of the following? If so please circle and describe:

Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

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Have you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

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Please list current prescription medications with dosage (psychiatric and general health):

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Please list any previous psychiatric medications (with dosage and dates): \_\_\_\_\_

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Do you drink alcohol or use recreational drugs? If so, what kind and how often? \_\_\_\_\_

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Do you or anyone close to you consider your use to be a problem? Yes    No

Who is your primary care physician? \_\_\_\_\_

Who is your psychiatrist (if applicable)? \_\_\_\_\_

When was your last complete physical exam (month/year)? \_\_\_\_\_

How many times a week do you exercise? \_\_\_\_\_ What type and how many minutes? \_\_\_\_\_

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What kinds of foods do you regularly eat? \_\_\_\_\_

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**YOUR FAMILY GROWING UP (Family of Origin)**

	MOTHER	FATHER
Current age, or If deceased date, age, and cause of death		
Country of Origin		
Religious/Spiritual Affiliation (if any)		
Use 3 adjectives or more to describe <u>each</u> parent		

<p><b>How did you and <u>each</u> parent get along when you were growing up?</b> Give some examples of things that you did together &amp; feelings you had.</p>		
<p><b>Use 3 adjectives or more to describe your parents' relationship</b></p>		
<p><b>How did your parents get along?</b> What were any things they disagreed over?</p>		
<p><b>Years married or together</b></p>		
<p><b>If divorced or not together, your age at divorce</b></p>		
<p><b>Reason for divorce/split</b></p>		
<p><b>Describe your relationship with step-parents (if any)</b></p>		
<p><b>List anyone else who lived with you <u>or</u> regularly cared for you</b></p>		
<p><b>Were you adopted? Age?</b></p>	<p><b>If so, please write any relevant information about your biological parents.</b></p>	
<p><b>List any major problems in your family growing up:</b></p>		

### Siblings

Please list all of your brothers and sisters in the order of birth.

First name	Biological (Yes/No)	Current Age	Male/Female	Married or Partnered? (Yes/No)	Describe your relationship in a few words

### Yourself

Where were you born? \_\_\_\_\_

Where did you live most of your childhood? \_\_\_\_\_

What was the highest grade of education you completed? \_\_\_\_\_

When you were a child, did you struggle with any of the following:

			<u>Age</u>
Learning disabilities	Yes	No	_____
Hyperactivity	Yes	No	_____
Bed wetting	Yes	No	_____
School fears	Yes	No	_____
Teasing/Bullying	Yes	No	_____
Eating disorders	Yes	No	_____
Witnessing violence in the home	Yes	No	_____
Sexual, physical or emotional abuse	Yes	No	_____

If so, at what age and by whom? \_\_\_\_\_

### **FAMILY MENTAL HEALTH HISTORY**

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

_____	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

### **CURRENT FAMILY, SOCIAL SUPPORTS, OCCUPATION & LIFE INTERESTS/ACTIVITIES**

#### **Intimate Relationships & Social Supports**

Are you currently married? Yes No      How long? \_\_\_\_\_

Are you currently partnered/in a romantic relationship? Yes No      How long? \_\_\_\_\_

Do you have any concerns about your current marital or romantic relationship that you would like to discuss?  
If so what are they?

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Are you currently separated or divorced?      Yes No      How long? \_\_\_\_\_

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication: \_\_\_\_\_

\_\_\_\_\_  
 Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? Whom can you turn to for emotional and other forms of support?  
 \_\_\_\_\_  
 \_\_\_\_\_

**Children**

Please list your biological, adopted and/or stepchildren (if applicable)

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Describe your relationship in a few words

**Employment and/or Current Educational Situation**

Are you currently employed?      Yes    No                      Are you currently a student?      Yes    No

Please describe your current work or academic situation: \_\_\_\_\_  
 \_\_\_\_\_

Do you enjoy your work/school? Is there anything stressful about it? \_\_\_\_\_  
 \_\_\_\_\_

**Interests/Activities/Spirituality**

What are some of your interests & activities? \_\_\_\_\_  
 \_\_\_\_\_

Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable) :\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How much are each of the following areas currently a problem for you?

Not at all      A little      Somewhat      Considerably      Terribly

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Marital Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Identity Problems	1	2	3	4	5
Job/School	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder/Struggles	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Have you experienced any unusually severe stresses during the last year? Yes    No  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What do you consider to be your strengths? \_\_\_\_\_  
 What do you consider to be your areas of needed growth? \_\_\_\_\_  
 Is there any other information you'd like to add? \_\_\_\_\_  
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