11920 Sawhill Blvd., Spotsylvania, VA 22553
Ph 540-317-1165 Fax 540-301-5657

Adult Intake

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.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):
_____

(Last) (First) (Middle Initial)
Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Names and Ages _____

_____

Local Address:
_____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: ( ) - May I leave a msg? □Yes □No

Cell/Other Phone: ( ) - May I leave a msg? □Yes □No
May I text you? □Yes □No

E-mail: _____ May I email you? □Yes □No
*Please be aware that email might not be confidential.

Referred by: _____

PERSONAL MENTAL HEALTH HISTORY
Within the past month have you experienced any of these symptoms or dealt with these difficult issues?

Please Rate Your Mood over the Past 2 weeks on a scale of 1-10 (10 being the best) _____
Mood Swings yes/no
Anxiety yes/no
Panic Attacks yes/no
Sleep Disturbances yes/no
- Trouble Falling Asleep yes/no
- Trouble Staying Asleep yes/no
- Sleeping Too Little yes/no
- Sleeping Too Much yes/no
- Disturbing Dreams yes/no

Hallucinations yes/no If yes, what type? Auditory yes/no Visual yes/no
Unexplained Losses of Time yes/no
Unexplained Memory Lapses yes/no
Frequent Body Complaints (such as headaches, constant body pain, ulcers) yes/no If yes, please list _____
Repetitive Thoughts (e.g., Obsessions) yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes/no
Suicide Attempt yes/no

FAMILY MENTAL HEALTH HISTORY
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

DISORDER:	FAMILY MEMBER:
Depression yes/no	
Bipolar Disorder yes/no	
Anxiety Disorders yes/no	
Panic Attacks yes/no	
Schizophrenia yes/no	
Alcohol/Substance Abuse yes/no	
Eating Disorders yes/no	
Learning Disabilities yes/no	
Trauma History yes/no	
Suicide Attempts yes/no	
Inpatient mental health hospitalization yes/no	
Alcohol/Substance Abuse Rehab yes/no	

CURRENT AND PREVIOUS MENTAL HEALTH TREATMENT

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □Yes □No

If Yes, with whom? _____

If Yes, would you like me to collaborate with them for the continuity of your care? Yes No

Have you had previous psychotherapy?
□No
□Yes,
Previous therapist's name if you remember _____
When did you see this mental health practitioner and for how long?
_____

Are you currently taking prescribed psychiatric medication (antidepressants, sleep aid, anti-anxiety or others)? □Yes □No
If Yes, please list: _____
Who is the prescribing physician? _____

If no, have you previously been prescribed psychiatric medication?
□Yes □No
If Yes, please list: _____

Have you ever been hospitalized for mental health issues?
□Yes □No
If Yes, when and for how long? _____
_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any chronic medical conditions you have been diagnosed with (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
_____
_____
_____

3. How many times per week do you exercise? _____
Approximately how long each time? _____

4. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

5. Do you regularly use alcohol? □ No □ Yes
In a typical month, how often do you have 3 or more drinks in a 24-hour period?_____
Have you ever felt you should cut down on your drinking? □ No □ Yes
Have people annoyed you by criticizing your drinking? □ No □ Yes
Have you ever felt bad or guilty about your drinking? □ No □ Yes
Have you ever had a drink in the morning to steady your nerves or get rid of a hangover (eye opener) □ No □ Yes

6. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never
Please circle drugs you have used: Cannabis, Cocaine, Heroin, Benzos, Hallucinogens (PCP, LSD, Acid), Pain Medications, Stimulants, Ecstacy

7. Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10 (10 being the best) how would you rate the quality of your current relationship? _____

8. In the last year, have you experienced any significant life changes or stressors such as separation, divorce, loss of job, loss of loved one? Please describe:
_____
_____
_____
_____

OCCUPATIONAL INFORMATION:
Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____
If yes, are you happy at your current position? _____
Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? □ No □ Yes
If yes, what is your faith? _____

OTHER INFORMATION:

What do you consider to be your strengths (e.g. creativity, open mindedness, love of learning, kindness, leadership, reliable, humor)?

What are effective coping strategies that you've learned (breathing, meditation, relaxation, exercise)?

What are your goals for therapy?