ANSWERS WITHIN

ADULT INTAKE FORM

Last Name	***First Name***

DOB:	***Allergies:***

Race: ☐ ***Native American or Alaska Native*** ☐ ***Asian*** ☐ ***Black/African*** ☐ ***Native Hawaiian/Pacific Islander*** ☐ ***Caucasian*** ☐ ***Hispanic***

Contact Information:

Street Address	***City, State, Zip***

Phone #	***Email***

Emergency Contact Information:

Name and Relationship to Client : Phone Number:

Name and Relationship to Client : Phone Number:

Do we have your permission to discuss your case with certain specified relatives and/or friends of your choosing?

Spouse – ☐ **Yes** ☐ **No Name:** _____

Others – Name/Relationship: _____

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PERSONAL HISTORY INVENTORY AND ASSESSMENT

General Information

What is the presenting issue(s)?

_____

_____

Problems Inventory

I am currently experiencing the following problems (please check all that apply):

- ☐ Relationship/marital problems
- ☐ Physical abuse
- ☐ Problems at work/school
- ☐ Losing someone or something close to me (person, pet, moving, etc.)
- ☐ Problems with people/family members
- ☐ Sexual abuse
- ☐ Current problems from past sexual abuse
- ☐ Alcohol abuse
- ☐ Drug abuse

- ☐ Feeling guilty about past misdeeds
- ☐ Feeling that I am no good
- ☐ Feeling the need to get more sleep
- ☐ Losing pleasure in my daily activities
- ☐ Often feeling restless or irritable
- ☐ Thinking about dying or killing myself
- ☐ Trouble keeping my mind on a task
- ☐ Feeling sad or "down in the dumps"

- ☐ Preoccupied with sexual thoughts or urges
- ☐ Needing less sleep than usual
- ☐ Spending sprees
- ☐ Trouble making myself slow down or talk less

- ☐ Fear of crowds, of a thing or public places
- ☐ Heart palpitations
- ☐ Chest pains or discomfort
- ☐ Feeling dizzy or unsteady
- ☐ Feeling things that aren't there

- ☐ Feeling the urge to avoid certain places or objects
- ☐ Feeling troubled by repetitive thoughts
- ☐ Feeling anxious and nervous
- ☐ Worrying about things over and over

- ☐ Checking, hand washing, hair pulling
- ☐ People following me, out to hurt me, or talking about me
- ☐ People reading my thoughts
- ☐ Hearing voices
- ☐ Thoughts being put into my head, controlling me, making me do things
- ☐ Special messages to me from TV or radio

- ☐ Feeling emotionally "numb"
- ☐ Recurring nightmares
- ☐ Frequently feeling startled
- ☐ Being troubled by painful memories

- ☐ Problems with my memory
- ☐ Knowing where or who I am
- ☐ Getting lost or confused

- ☐ Having trouble remembering my past
- ☐ Finding things, I don't remember having
- ☐ Feeling that I've lost time

- ☐ Difficulty controlling my temper
- ☐ Feeling anger or resentment

- ☐ Taking laxatives to control my weight
- ☐ Vomiting to control my calorie intake
- ☐ Exercising frequently and vigorously
- ☐ Fasting in order to control my weight
- ☐ Feeling helpless about my eating habits
- ☐ Extreme changes in my weight

Any other problems not mentioned above?

_____

_____

_____

_____

ANSWERS WITHIN

MEDICAL HISTORY

Primary Care Physician's Name: _____Telephone Number: _____

Date of Last Physical Exam: _____

Have you ever been struck in the head, knocked unconscious before? ☐ Yes ☐ No If yes, please explain: _____

_____

Medical Concerns/Diagnosis(es)

_____

_____

_____

_____

Family Medical History

_____

_____

Current Medication(s)

(Please include prescription, over the counter medications (OTC), and vitamins, supplements and herbal remedies and as needed medications you may take infrequently)

Name	Dose & Direction	Reason/How Long

**Please use back of sheet of additional sheet of paper for additional meds.*

Childhood Illnesses / Hospitalizations / Surgeries (please include dates)

_____

_____

For Women Only:

Regular Cycles? ☐ Yes ☐ No Date of last menstrual cycle: _____Current Birth Control: _____

Age of first menses?_____# of Pregnancies _____ Are you currently breast feeding? ☐ Yes ☐ No

Currently pregnant or planning a pregnancy? ☐ Yes ☐ No If yes, due date/when? _____

PSYCHIATRIC HISTORY

Outpatient treatment ☐ Yes ☐ No If yes, please describe when, by whom and nature of treatment

_____

_____

Psychiatric hospitalization ☐ Yes ☐ No If yes, please describe for what reason, when and where.

_____

_____

Is there a history of mental illness, alcohol/drug dependence or suicide in your family? ☐ Yes ☐ No, if yes, please describe

_____

_____

Do you know if they took medication for their mental illness and if so, what was the name of it? _____

_____

Psychiatric Diagnosis ☐ Yes ☐ No (if yes, please list your diagnosis)? _____

Please list any medications for your mental illness that you have tried and ***HAVE NOT*** worked or cause you side effects:

_____

SOCIAL HISTORY

Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Committed Relationship

What are your children(s) name(s), age(s), and gender? _____

_____

Family/Others Residing in the Home:

_____

_____

_____

Education

Highest Grade/Degree Completed:

Did you have an IEP or 504 plan while in school? ☐ Yes ☐ No

Occupational

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Stay at home

If you are currently employed where do you work? _____

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Cultural Beliefs/Preferences

Do you have any religious, social or cultural beliefs that you would like me to be aware of? ☐ Yes ☐ No

If yes, explain: _____

Substance Use/Abuse

Do you now or have you ever consumed/used:

Tobacco? ☐ Yes ☐ No How much per day? _____ #years? _____Age started? _____ Last used? _____

Alcohol? ☐ Yes ☐ No How much per day? _____ #years? _____Age started? _____ Last used? _____

Illicit substance (Marijuana, Meth, Coc, Heroin, Ecstasy, Other) ☐ Yes ☐ No

How much per day? _____ #years? _____Age started? _____ Last used? _____

Legal

Have you ever been: ☐ Arrested ☐ Warrant(s) ☐ Conviction(s) ☐ Detention ☐ Probation ☐ Parole ☐ Incarcerated

If you answered yes, please explain: _____

_____

Recreation/Leisure

Hobbies/Interests:_____

Sexual History

Gender Identity:_____Sexual Orientation:_____

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect ☐ Yes ☐ No

Please describe when, where and by whom:_____

_____

Military

Have you ever served in the military? ☐ Yes ☐ No (If you answered no this please skip the remaining questions)

Branch of service: _____Tour of duty dates: _____Discharge/Type of Discharge: _____

Combat duty ☐ Yes ☐ No If yes, when & where? _____

_____	_____	_____
Patient Printed Name	***Parent/Legal Guardian Signature***	***Date***