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ADULT INTAKE & HEALTH HISTORY FORM

Date:___________________________

Name:____ Age:________DOB:______________

Address:____

____

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

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

E-mail: ____ May I email you? □ Yes □ No

Referred by: ______________________________________

Can I thank them for connecting you with me? □ Yes □ No

If other than client, name of person completing this form and relationship to client:

____

What is the reason for the visit today? ____

____

Who is requesting or recommending these services? (circle all that apply)

Self **Therapist** **Physician** **Psychiatrist**

Attorney **DFCS** **Court** **Other**? __________________

Relationship Status: (check all that apply)

☐ Married ☐ Separated ☐ Divorced ☐ Dating ☐ Living Together ☐ Living

Apart Length of time in current relationship:________

Number of Children: __________________

Have you had previous therapy?

□ No □ Yes, previous therapist's name: ____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

OCCUPATIONAL/SCHOOL INFORMATION:

Are you currently employed?

□ No □ Yes If yes, who is your current employer/position? ____

If yes, are you happy at your current position? ____

Are you currently a student? □ No □ Yes, school's name: ____

Please list any work-related/school stressors, if any:____

SPIRITUAL INFORMATION:

Is spirituality part of your life? ☐ Yes ☐ No

If yes, what is your faith?

Could spirituality discussions be part of the counseling process? ☐ Yes ☐ No

HEALTH INFORMATION:

1. In the last year, have you experienced any significant life changes or stressors? If yes, please explain.

____

____

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____

3. Are you currently taking prescribed psychiatric medication (antidepressants or others)?

□ No □ Yes If Yes, please list: ____

4. Are you having any problems with your sleep habits? □ No □ Yes If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other__________________

5. 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

6. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

7. Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? ☐ Yes ☐ No If yes, how often?________________________

8. Have either you or your partner struck, physically restrained, used violence against or injured the other person?

☐ Yes ☐ No If yes for either, who, how often, and what happened?

____

____

CHECK THE FOLLOWING THAT APPLY:

___Depression ___Anxiety ___Self-harming behavior
___Mood swings ___Low motivation ___Low self-esteem
___Suicidal ideation ___Hallucinations ___Bizarre or strange behavior
___Hyperactivity ___Difficulty focusing ___Difficulty concentrating
___Aggression ___Anger ___Poor social skills
___Poor eye contact ___Poor memory ___Organization problems
___Eating disorder symptoms Low frustration tolerance

Are there any additional problems or concerns? If yes, briefly describe: ____________________________

____

MEDICAL HISTORY

Any delays with developmental milestones (talking, walking, etc.)?
YES **NO** If yes, please explain: ____

____

Date of last visit to a primary care physician or other medical doctor? __________________
Any concerns at that time? **YES** **NO**
If yes, please explain): ____

Hearing or vision problems? **YES** **NO**
If yes, are they corrected (glasses, contacts, hearing aids)? ________________________________

Have you ever been hospitalized for medical reasons (not psychiatric) ? **YES** **NO**
If yes, reason and approximate date(s): ____

____

Have you ever had surgery? **YES** **NO**
If yes, please describe: ____

Do you have any chronic illness (diabetes; asthma, etc.)? **YES** **NO**
If yes, please briefly ____

____

Do you have any medication, food, or other allergies? **YES** **NO**
If yes, please briefly describe)? ____

Do you ***currently*** take any prescription medications (non-psychiatric)? **YES** **NO**
If yes, medication names: ____

Have you ever had any head injuries? **YES** **NO**
If yes, briefly describe: ____

Have you ever had any other major injuries? **YES** **NO**
If yes, briefly describe ____

Do you have any appetite problems or problematic weight gain or weight loss? **YES** **NO**
If yes, briefly describe: ____

Do you have any problems with your sleep? **YES** **NO**
If yes, briefly describe: ____

FAMILY HISTORY

Parents' names: ____

Mother, living or deceased?_____________ Father, living or deceased? _____________

Names and ages of your siblings: ____

____

Who currently lives in your home? ____

____

Check any family current or recent stressors:
(described further in the comments section below as needed)

____Separation or divorce
____New job
____Death of a family member
____Death of a pet
____Substance abuse problem of a family member
____Other ____

_____Move to a new home
_____Loss of a job
_____Birth of a child
_____Serious illness of a family member

Recreational activities? ____

Relationship status? (circle one) **Married** **partnered** **single** **divorced** **widowed**

EDUCATIONAL HISTORY

Highest grade or educational level achieved: ____________________

Did you repeat any grades? (if yes, which one?) ____

Did you receive any special education services? **YES** **NO**

If yes, for what reason? (circle all that apply) **behavioral** **emotional** **academic difficulty**

Any major behavioral problems in school, or major school discipline (such as suspensions, expulsions)? **YES** **NO**

If yes, briefly describe: ____

MENTAL HEALTH HISTORY

Have you ever received a mental health diagnosis in the past? **YES** **NO**
If yes, what diagnosis? ____

Have you ever seen a psychiatrist for psychiatric medication? **YES** **NO**
If yes: Name of psychiatrist?____________________When? ______________________________

Are your ***CURRENTLY*** taking psychiatric medications? **YES** **NO**
If yes, name(s) of medication(s): ____
When was your last appointment? ________________
How long have you received treatment by a psychiatrist (months, years)? _________________

Have you taken any other psychiatric medication in the past? **YES** **NO**
If yes, names of medications and dosages (if known): ___________________________________
____

Have you ever had a psychological evaluation? **YES** **NO**
If yes, when and what was the diagnosis? ____

Are your ***CURRENTLY*** receiving therapy or counselling for emotional or behavioral problems?

(circle all that apply)	Provider or Agency	Date Started	Frequency	For what issues?
Individual				
Group				
Family				
Other				

Have you received therapy or counseling in the ***PAST*** for emotional or behavioral problems?

(circle all that apply)	Provider or Agency	Date Started	Date Stopped	Why did the therapy stop?
Individual				
Group				
Family				
Other				

Have you ever been admitted to a psychiatric hospital? **YES** **NO**

If yes, please list date(s) and name(s) of hospitals: ____

____

Have you ever had suicidal thoughts or made suicidal threats? **YES** **NO**

If yes, briefly describe: ____

____

Have you made any suicide attempts? **YES** **NO**

If yes, briefly describe: ____

____

Have your ever been abused or neglected? **YES** **NO**

If yes, circle those that apply and briefly describe:

(circle all that apply)	Briefly describe
Physical	
Verbal / Emotional	
Sexual	
Neglect	

Do you have any family history of mental health problems? **YES** **NO**

If yes, briefly describe: ____

How were you disciplined as a child? ____________________________________

Do you believe it was abusive or excessive? **YES** **NO**

If yes, briefly describe: ____

Have you ever had anger management issues, either now or in the past? **YES** **NO**

If yes, briefly describe: ____