



ADULT INTAKE FORM

(Please complete in ink)

1. Full Name: _____ Sex: _____ DOB: _____

2. Contact Ph #: _____ Email: _____

3. Mailing Address: _____

4. Emergency Contact Name and Telephone #: _____

5. Primary Care Physician: _____

6. Do you give permission for regular updates to your primary care physician? Yes ___ No ___

What is the problem(s) for which you are seeking help?

1. _____

2. _____

3. _____

Current Symptoms Checklist (check for any symptoms present):

() Racing thoughts () Excessive worry () Suspiciousness

() Impulsivity () Anxiety attacks () Excessive guilt

() Increased risky behavior () Avoidance () Increased irritability

() Increased libido () Hallucinations () Excessive energy () Decreased need for sleep

List ALL current prescription medications and how often you take them (if none, write none).

Medication:

Dose:

When Started:

List any current over-the-counter medications/supplements/vitamins:

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect?

Yes ____ No ____ If yes, please describe when, where, and by whom: _____

Have you been exposed to Domestic Violence? Yes ____ No ____

Legal History

Have you ever been arrested? Yes ____ No ____

Do you have any pending legal problems? If so, please briefly explain: _____

Past Psychiatric History

Any outpatient treatment? Yes ____ No ____ If yes, please describe below:

Reason:

Dates:

Provider:

Psychiatric Hospitalization

Any psychiatric hospitalizations? Yes ____ No ____ If yes, please describe below:

Reason:

Date/Length of stay:

Hospital:

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder () Yes () No

Schizophrenia () Yes () No

Depression () Yes () No

Post-traumatic stress () Yes () No

Anxiety () Yes () No

Alcohol abuse () Yes () No

Anger () Yes () No

Violence () Yes () No

Other substance abuse () Yes () No

Suicide () Yes () No

If yes, who had each problem? _____

Past Psychiatric Medications

If you have ever taken any of the following medications, please state if they were helpful and any side-effects you remember (it is ok if you do not remember all aspects, please fill in what you can).

WHEN:

DOSE:

RESPONSE/SIDE EFFECTS:

Antidepressants:

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Other _____

Mood Stabilizers:

Tegretol (carbamazepine) _____

Lithium _____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Topamax (topiramate) _____

Other _____

Antipsychotics/Mood Stabilizers:

Abilify (aripiprazole) _____

Risperdal (risperidone) _____

Seroquel (quetiapine) _____

Zyprexa (olanzapine) _____

Geodon (ziprasidone) _____

Clozaril (clozapine) _____

Past Psychiatric Medications- continued

If you have ever taken any of the following medications, please state if they were helpful and any side-effects you remember (it is ok if you do not remember all aspects, please fill in what you can).

WHEN:

DOSE:

RESPONSE/SIDE EFFECTS:

Antipsychotics/Mood Stabilizers (cont.):

Haldol (haloperidol) _____

Prolixin (fluphenazine) _____

Other _____

Sleep Medications:

Ambien (zolpidem) _____

Sonata (zaleplon) _____

Rozerem (ramelteon) _____

Restoril (temazepam) _____

Desyrel (trazodone) _____

Other _____

ADHD Medications:

Adderall (amphetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Strattera (atomoxetine) _____

Other _____

Antianxiety medications:

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Other _____

Substance Use

Do you think you may have a problem with alcohol or drug use? () Yes () No

Have you ever been treated for alcohol or drug use or abuse? () Yes () No

If yes, for which substances? _____

If yes, where were you treated and when? _____

Check if you have ever tried the following: If yes, how long and when did you last use?

Cocaine () Yes () No _____

Stimulants (pills) () Yes () No _____

Heroin () Yes () No _____

Methamphetamine () Yes () No _____

Marijuana () Yes () No _____

Pain killers (not prescribed) () Yes () No _____

Methadone () Yes () No _____

Sleeping pills () Yes () No _____

Alcohol () Yes () No _____

Ecstasy () Yes () No _____

Other () Yes () No _____

***How many caffeinated beverages do you drink a day?** Coffee ____ Sodas ____ Tea ____

Energy Drinks ____ None ____

Do you currently smoke cigarettes? () Yes () No

How many packs currently per day on average? ____ How many years? ____

Have you smoked in the past? () Yes () No

How many years did you smoke? ____ When did you quit? ____

Do you currently smoke a pipe, cigars, or use chewing tobacco? () Yes () No

How often per day on average? ____ How many years? ____

Have you used a pipe, cigars or chewing tobacco in the past? () Yes () No

How often per day on average? ____ How many years? ____

Family Background and Childhood History

Where did you grow up? _____

List your siblings and their ages: _____

Has anyone in your immediate family died? _____

Medical History

Current Weight: _____ Height: _____

Any allergies? _____

Current medical problems: _____

Past medical problems (Including surgeries and prolonged hospital stays): _____

Your Exercise Level

Do you exercise regularly? () Yes () No How often? _____

FOR WOMEN ONLY: Date of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? () Yes () No

Are you planning to get pregnant in the near future? () Yes () No

Birth control method: _____

How many times have you been pregnant? _____ How many live births? _____

Personal and Family Medical History

Check if yourself or anyone in your family has had any of the following:

Thyroid Disease Yourself () Family() Anemia Yourself () Family()

Liver Disease Yourself () Family() Chronic Fatigue Yourself () Family()

Kidney Disease Yourself () Family() Diabetes Yourself () Family()

Asthma/respiratory problems Yourself () Family()

Stomach or intestinal problems Yourself () Family()

Cancer (type) _____ Yourself () Family()

Personal and Family Medical History- continued

Check if yourself or anyone in your family has had any of the following:

Fibromyalgia Yourself () Family() Heart Disease Yourself () Family()

Epilepsy or seizures Yourself () Family() Chronic Pain Yourself () Family()

High Cholesterol Yourself () Family() High blood pressure Yourself () Family()

Head trauma Yourself () Family() Liver Problems Yourself () Family()

Other _____ Yourself () Family()

Educational History

Highest Grade Completed? _____

Did you attend college? () Yes () No If yes, Where? _____ Major? _____

Occupational History

Are you currently: () Working () Student () Unemployed () Disabled () Retired

How long in present position? _____

What is/was your occupation? _____

Have you ever served in the military? () Yes () No

Relationship History and Current Family

Are you currently: () Married () Partnered () Divorced () Single () Widowed How long? ____

If not married, are you currently in a relationship? () Yes () No; If yes, how long? _____

Are you sexually active? () Yes () No

How would you identify your sexual orientation?

() straight/heterosexual () lesbian/gay/homosexual () bisexual () transsexual

() unsure/questioning () asexual () other () prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? () Yes () No;. If so, how many?

Do you have children? () Yes () No; If yes, list ages and gender: _____

List everyone who currently lives with you: _____

Spiritual Life

Do you belong to a particular religion or spiritual group? () Yes () No

If yes, what is the level of your involvement? _____

Does your involvement make things: () more helpful () more stressful

Please explain: _____

Other comments or concerns

Printed Name: _____

Signature: _____ **Date:** _____

For Office Use Only

Name of Person Receiving Forms: _____

Signature: _____ Date: _____