PSYCHOTHERAPY BIOPSYCHOSOCIAL INTAKE - ADULT

Name:		**Today's Date:**	
Address:		**Date of Birth:**	
Telephone No.:		**Email Address:**	
Pre-existing Diagnoses	1. 2.	**Current Medications:**	**1.** 3.
Marital Status:	1. Single 2. Married 3. Divorced	**Number of Children:**	

Presenting Problem(s)

1. Please describe what brought you in today?					
2. How long have you experienced this problem?					
3. Please circle the number that matches the severity of the problem (1=mild 5=severe)	1	2	3	4	5
4. How is the problem interfering with your daily function? . .					
5. What are your best hopes for treatment?					
6. What would improve if treatment is successful?					

CURRENT SYMPTOMS							
Aggression		Restlessness		Hopelessness		Excessive Guilt	
Agitation		Impulsivity		Insomnia		Racing Thoughts	
Anger		Irritability		Fatigue		Poor Memory	
Anhedonia		Distractibility		Sad		Panic Attacks	
Anxiety		Emotionality		Worried		Poor Concentration	
Depress Mood		Worthlessness		Hearing Things		Suicidal Thoughts	
Fearfulness		Self-deprecation		Seeing Things		Thought Disorder	
Loss of Interest		social withdrawal		Delusions		Change in Appetite	

SUBSTANCE USE & ADDICTION HISTORY (Please mark the box(s) below that apply to you)

Would you or someone you know say you have a problem with	Gambling	Pornography	Shopping	Other
Would you or someone you know say you have a problem with	Alcohol	Cannabis	Cocaine	Other
Have you ever been treated for addiction? (tick box(s))	**Yes**			
Does your family have a history of addiction? (tick box(s))				
If you chose "Other" please specify:				

ADVERSE CHILDHOOD EXPERIENCES (Please tick the boxes below that apply to you)		
1	Did an adult in your household **often** swear, insult, humiliate you or cause you to be fearful?	
2	Did an adult in your household **often** push, grab, slap, or throw things at you or injure you?	
3	Did an adult at least 5 years older than you **ever fondle you or** try to have sex with you?	
4	Did you **often not** have enough to eat, had to wear dirty clothes, or feel unprotected?	
5	Did you **often** feel unloved and unwanted or no one in your family loved you?	
6	Were your parents **ever** separated or divorced?	
7	Was your mother **Often** pushed or beaten repeatedly or threatened with a gun or knife?	
8	Did you live with anyone who abused drugs or alcoholic?	
9	Was a household member depressed or mentally ill or attempted suicide?	
10	10. Did a household member go to prison?	
	SCORE	

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GLOBAL ASSESSMENT OF RELATIONAL FUNCTION (GARF)				
Instructions: On a scale 0f 1-10 (1=worst and 10 = best) Please score your childhood family in the boxes on the left				
A. Problem solving/interactional skills		**B. Family Organization and Structure**		
How did your family:		**In your family did:**		
	Adapt to stress		Each individual some personal "space"	
	Communicate		They keep "space" for parents separate from kids	
	Resolving conflict		Parents working together to lead this family effectively	
	Negotiate of family goals, rules and routines		Power & responsibility get distributed appropriately	
	Total Section A		**Total Section B**	
C. How family members feel about the family		**Scores**	**Profile**	**GARF**
	Freedom to express emotions	81 – 90+	Satisfactory	
	Showing Love and affection to each other	61 - 80	Somewhat Unsatisfactory	
	Sharing of values	41 - 60	Predominantly unsatisfactory	
	Showing respect & regard for each other	21 - 40	Rarely Satisfactory	
	Maintain sexually appropriate behavior	10 - 20	Chaotic	
	Total Section C	0 - 9	Inadequate Information	
Clinician Instructions: GARF Score: sum individual subcategories ABC ÷ no. of responses x 10. Add Sum of ABC ÷3				

Informed Consent to Treatment (Please read and sign)

This is an informed consent agreement for psychotherapy services between the undersigned. This agreement aims to inform you about the nature of the therapeutic process, the limits of confidentiality, the risks and benefits of therapy, and to obtain your consent to participate in therapy.

Nature of Therapy: Psychotherapy involves meeting with a therapist to explore your mental health and well-being concerns. The focus of therapy will depend on your needs and goals and may involve discussing your, thoughts, feelings, behaviors, and relationships. The therapist may use various therapeutic techniques to help you achieve your goals.

Confidentiality: All information shared in therapy will be kept confidential, with the following exceptions. (1) If the therapist believes you are a danger to yourself or others. (2) If the therapist believes a child is being abused or neglected, and (3) If the therapist is ordered by a court to disclose information.

Benefits and Risks of Therapy: Therapy can help you gain insight into your thoughts, feelings, and behaviors and can also improve relationships, reduce stress and anxiety, and increase wellbeing. However, therapy may also involve discussing painful or difficult experiences, which can be emotionally challenging. Further, therapy may not work for everyone, so there is no guarantee that therapy will produce the results you desire.

Consent to Treatment: By signing below, you acknowledge that you have read and understood the information and agree to participate in psychotherapy, you also agree to be financially responsible for all sessions attended.

Date: _____

Patient Name:_____ **Psychotherapist Name:**_____

Signed:_____ **Signed:**_____