# Adult Intake Form

(Ages 19+)

| | |
|---|---|
| **Name** | |
| **Date of Birth** | |
| **Mailing Address** | |
| **Phone Number**<br>**Cell Phone?: Y / N** | |
| **E-mail Address** | |

**What are the main concerns you are currently seeking help for?**

**How are these concerns impacting your job performance, daily living abilities, relationships, etc.?**

## Physical

***Please check the box to indicate any problems you have been identified as having:***

- ☐ Alertness
- ☐ Anger
- ☐ Appetite
- ☐ Brain injury
- ☐ Cancer
- ☐ Chronic Fatigue Syndrome
- ☐ Concentration
- ☐ Constipation
- ☐ Diabetes
- ☐ Dizziness, tingling sensation
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Frequent headaches
- ☐ Frequent stomachaches
- ☐ Heartburn/gastroesophageal reflux
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypoglycemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritability
- ☐ Loss of feeling in part of your body
- ☐ Memory
- ☐ Migraines
- ☐ Pain
- ☐ Reading
- ☐ Sadness
- ☐ Sense of Direction
- ☐ Shakiness
- ☐ Shortness of breath
- ☐ Seizures
- ☐ Sleep
- ☐ Speech
- ☐ Weakness
- ☐ Weight gain/loss
- ☐ Writing

***Please list ALL medications you are currently taking:***

| Medication | Dose | How Often | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Neuropsychological Functioning

***Current Issues – Please check all that apply.***

**Attention**

- ☐ Frequently missing details, making careless errors
- ☐ Difficulty paying attention for long periods of time
- ☐ Easily distracted
- ☐ Difficulty following instructions

**Learning & Memory**

- ☐ Difficulty remembering recent events, names, faces, the date, etc.
- ☐ Difficulty learning and remembering new information

**Processing Speed**

- ☐ Difficulty thinking quickly
- ☐ Feeling as though most people talk too fast
- ☐ Taking longer to complete tasks than before
- ☐ Frequently asking people to repeat themselves (not due to hearing difficulty)

**Executive Functioning**

- ☐ Acting before thinking
- ☐ Difficulty problem solving, or making bad decisions
- ☐ Difficulty following multi-step directions
- ☐ Difficulty planning and organizing

**Speech & Language**

- ☐ Difficulty with word finding
- ☐ Difficulty with speaking 'off the cuff'
- ☐ Difficulty understanding others or following conversations

## Psychological

| Current Stressors | Please elaborate |
|---|---|
| Family | |
| Intimate Relationships | |
| Occupational | |
| Legal | |
| Friends | |
| Economic | |
| Housing | |

***Please indicate how often you experience the following:***

| | Not at all | 1-2 Days/week | 3-4 Days/week | Everyday |
|---|---|---|---|---|
| Have thoughts of self-harm | | | | |
| Feel sad, empty, hopeless | | | | |
| Cry easily and frequently | | | | |
| Am irritable, moody, sullen, pouts | | | | |
| Have lost pleasure in activities previously enjoyed | | | | |
| Sleep too much or too little | | | | |
| Seem restless | | | | |
| Behaviors seemed to be slowed down; seem listless | | | | |
| Fatigue/loss of energy | | | | |
| Feelings of worthlessness | | | | |
| Excessive or inappropriate guilt | | | | |
| Negative & self-critical thoughts | | | | |
| Decreased ability to think or concentrate | | | | |
| Socially withdrawn & isolated | | | | |
| Is indecisive & easily confused | | | | |
| Complain of stomachaches & headaches | | | | |
| Feel nervous, anxious, restless, on edge | | | | |
| Excessive worrying, irritable, impatient | | | | |
| School refusal | | | | |
| Trouble relaxing and sitting still & restlessness | | | | |
| Is afraid that something 'bad' is going to happen | | | | |
| Engages in repetitive behaviors to manage the worry | | | | |
| Easily fatigued, sleep disturbance, muscle tension | | | | |

Are you currently working with a therapist? Yes/No. If yes, the name and address of your therapist: _____

_____

**Suicide/Self Harm History:**

Have you ever tried to harm or kill yourself? _____

_____

Do you have current thoughts, intent or a plan to harm or kill yourself? _____

_____

_____

## Social

Have there been any recent stressful life events? (Please check all that apply)

- ☐ Divorce/Separation
- ☐ Financial Problems
- ☐ Substance Abuse
- ☐ Death of Family/Friend/Pet
- ☐ Marriage
- ☐ Change in Job Status
- ☐ Disagreement about Parenting
- ☐ Relationship Conflict
- ☐ Sibling Conflict

**Work History:**

Are you employed outside the home? _____

_____

If yes, what is your occupation? _____

_____

How many hours per week do you work? _____

_____

If no, are you unable to work because of an injury or illness? Please explain. _____

_____

## School History:

Did you ever repeat a grade? If yes, which grades? _____

_____

Were you ever placed in special classes? If yes, for what subjects and which grade? _____

_____

Do you have a history of learning challenges? Please explain. _____

_____

_____

| | Name of School | Year Graduated | Degree | Major |
|---|---|---|---|---|
| High School | | | | |
| 2 Year College | | | | |
| University | | | | |
| Post Graduate Study | | | | |

## Substance History

Have you ever used drugs or alcohol? _____

_____

Do you have any history of any recreational drug use? _____

_____

***Substance(s) Used – please check all that apply:***

- ☐ Amphetamines/Speed
- ☐ Barbiturates/Downers
- ☐ Opiates
- ☐ Cocaine
- ☐ Psychedelics (e.g. LSD, Ecstasy, bath salts)
- ☐ Inhalants (e.g. glue, aerosols)
- ☐ Cannabis/Marijuana/Hashish
- ☐ Benzodiazepines
- ☐ PCP

Did you receive any treatment for substance abuse? _____

_____

Please add any additional treatment information: _____

_____

_____

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? _____

_____