Adult Intake Form

Welcome to Falls Psychology Services. We look forward to providing you with excellent and efficient psychological services. Please take a few minutes to fill out this form. The information will help us to better understand your situation.

Personal Information

Client Name: _____ Date of Birth/Age: _____ SSN: _____

Sex: Female Male Transgender M to F Transgender F to M Other _____

Mother's Name: _____ Father's Name: _____

Street Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Is it okay to leave a message? Yes No

Cell Phone: _____ Is it okay to leave a message? Yes No

Email Address: _____ May we e-mail you? Yes No

Insurance Information

Name of Insurance Company:_____

Insurance Co. Phone # (Mental Health):_____

Policy Owner's Name:_____ Policy Owner's Date of Birth:_____

Policy Owner's SS#: _____

Insurance ID #:_____ Policy or Group#:_____

Policy Owner's Address (only if different than above):_____

Please be prepared to provide our office staff with your insurance card so that we may make a copy.

Presenting Problem

What brings you here today? (please be as specific as possible)

_____

_____

_____

Mental Health History/Information

Please circle all that apply to you (choose severity that applies).
(0) Not Present, (1) Mild, (2) Moderate, (3) Severe

Depression	**0 1 2 3**	Memory Problems	**0 1 2 3**	Panic Attacks	**0 1 2 3**
Anxiety	**0 1 2 3**	Loss of Interest	**0 1 2 3**	Obsessive Thoughts	**0 1 2 3**
Mood Swings	**0 1 2 3**	Irritability	**0 1 2 3**	Ritualistic Behavior	**0 1 2 3**
Appetite Changes	**0 1 2 3**	Excessive Worry	**0 1 2 3**	Checking	**0 1 2 3**
Sleep Changes	**0 1 2 3**	Suicidal Ideation	**0 1 2 3**	Counting	**0 1 2 3**
Hallucinations	**0 1 2 3**	Relationship Issues	**0 1 2 3**	Self-Injury	**0 1 2 3**
Racing Thoughts	**0 1 2 3**	Low Energy	**0 1 2 3**	Difficulty with	**0 1 2 3**
Confusion	**0 1 2 3**	Hyperactivity	**0 1 2 3**	Concentration	

Describe a brief history of your present symptoms:

_____

_____

What effect have they had on your life?

_____

_____

Have you ever been diagnosed with a mental health disorder? If yes, please describe:

_____

_____

Have you ever been treated for a mental health problem? If yes, please describe:

_____

_____

Have you ever had a mental health hospitalization? If yes, please describe:

_____

_____

Do you or have you ever: Felt suicidal? _____ Harmed yourself? _____

Attempted to end your life? _____ Felt homicidal? _____ Harmed someone else? _____

What best describes your mood? (circle all that apply):

Anxious Calm Sad Happy Angry Frustrated Worried Hopeless Helpless

Other:_____

Behavioral symptoms (check all that apply within the last month):

Decreased sleep ___, Appetite Change ___, Low Enjoyment of Life ___

Decreased Motivation ___, Impulsiveness ___, Can't Stop Talking ___,

Poor Judgment ___, Very High Energy ___, Very Low Energy ___, Fatigue ___

Guilt ___, Loss of Sex Drive ___, Poor Concentration ___, Racing Thoughts ___

Hearing Things Other People Do Not (e.g., voices) ___

Seeing Things Other People Do Not (e.g., shadows) ___ , Paranoia ___

Substance Use

Do you currently use any substances (i.e., tobacco, alcohol, marijuana, etc.)? ___ No ___ Yes

If yes, please provide the name of the substance(s), frequency, and amount of use:

_____

_____

Have you used substances in the past? ___ No ___ Yes

If yes, please provide the name of the substance(s), frequency, and amount of use:

_____

_____

Family Information

Where were you born? _____

Where do you live now? _____

How long have you lived where you are now? _____

Are your parents married? ___ No ___ Yes
If not, when did they divorce/separate?_____

Who do you live with? (list all people within the home – name, relationship, age):

_____

_____

_____

_____

Describe the family in which you were raised in:

_____

_____

How do you get along with members of the family?

_____

_____

How would you describe your childhood (e.g., happy, chaotic, troubled)?

_____

_____

Are you currently married? ___ No ___ Yes

If so, for how long? _____

Do you have children? ___ No ___ Yes; If yes, please list ages and genders:

_____

_____

_____

Is there any other family information that you want the counselor to know?

_____

_____

Is there a history of mental health or substance abuse problems in your family? ___ No ___ Yes
If yes, please explain:

_____

_____

_____

_____

Has you experienced any physical, emotional, or sexual abuse? ___ No ___ Yes
If yes, please explain:

_____

_____

Are there any guns or weapons in your home? _____ No _____ Yes
If yes, specify what type and where gun/weapon is stored:

_____

List/describe anything else you'd like us to know about your family and/or home life:

Medical History/Information

Previous Surgeries/Major Illness or Injury/Medical Diagnoses (please include reason and year):

_____

_____

Please list any additional health information that may be important for the counselor to know (including any medication or other allergies):

_____

_____

List daily medications and dosages (including over the counter medications)

Current Medication	Dosage	Prescribing Physician	Last Dose	Taking as Prescribed?

Are you having any difficulty with pain? ___ No ___ Yes; If so please describe:

_____

_____

_____

Have you ever experienced a traumatic brain injury? ___ No ___ Yes; If so please describe:

_____

Have you ever: Binged on food? _____ Gone without eating? _____

Vomited on purpose? _____ Used laxatives to purge? _____

Educational History

What is the highest grade you have completed?

_____

Did you receive special education services? ___ No ___ Yes; If so please explain:

_____

Did you have any learning or behavioral issues in school? ___ No ___ Yes; If so please explain:

_____

_____

Described your grades in school: _____

Were you ever held back a grade? ___ No ___ Yes; If so please explain:

_____

Have you ever been tested for intellectual disabilities? ___ No ___ Yes; If so please explain:

_____

Have you ever been tested for learning disabilities? ___ No ___ Yes; If so please explain:

_____

List/describe anything else you'd like us to know about your education:

Developmental History/Behavior Concerns

Please describe your development during early childhood –

Motor Milestones (crawling, walking, running): ___Normal, ___Delayed (please explain):

_____

_____

Cognitive Milestones (thinking, learning, problem solving): ___Normal, ___Delayed (please explain):

_____

_____

Self-Help Milestones (eating w/spoon, using sippy cup): ___Normal, ___Delayed (please explain):

_____

_____

Social/Emotional Milestones (understanding emotions): ___Normal, ___Delayed (please explain):

_____

_____

Speech/Language Milestones (talking): ___Normal, ___Delayed (please explain):

_____

_____

Do you regularly engage in social activities? ___ No ___ Yes; If not, please explain:

_____

_____

What are your hobbies or leisure activities?

_____

_____

Are you able to engage in hobbies or leisure activities? ___ No ___ Yes; If not, please explain:

_____

_____

Please describe your personality:

_____

_____

_____

Do you have any past or current involvement with the legal system? ___ No ___ Yes; If so please explain:

_____

_____

Job/Occupational History

Are you currently employed? ___ No ___ Yes; If not, when and where was your last place of employment?

_____

_____

How many jobs have you held? _____

How many jobs have you been fired from? _____

Have you ever had performance problems at work? ___ No ___ Yes; If yes, please explain:

_____

_____

Other Information

How satisfied are you with…. (circle one for each category)

Quality of Life: *Very Satisfied Satisfied Unsatisfied Very Unsatisfied*

Social Support: *Very Satisfied Satisfied Unsatisfied Very Unsatisfied*

Occupation: *Very Satisfied Satisfied Unsatisfied Very Unsatisfied*

Current Family Life: *Very Satisfied Satisfied Unsatisfied Very Unsatisfied*