Adult Psychotherapy Intake Form

Full Name _____ Today's Date_____

Male_____ Female_____ Date of Birth_____ Age_____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Is it OK to contact you at home? _____OK to leave a message? _____

Mobile Telephone _____ Is it OK to contact this number? _____OK to leave a message? _____

How did you learn about the psychotherapy services provided at this office: _____
_____

REASON FOR SEEKING TREATMENT:
Please briefly describe the problems you are experiencing.
_____
_____
_____
_____

What has happened to cause you to seek help now?
_____
_____

What do you hope to be able to do or achieve as a result of treatment?
_____
_____

How do you handle stressors and/or cope with the problems you have described:
_____
_____
_____

Do you currently have thoughts of harming yourself? □ yes □ no
Have you in the past? □ yes □ no If Yes, how long ago? _____

Do you currently have thoughts of wishing you were dead? □ yes □ no

Do you currently have urges to hurt, harm, or kill someone else? □ yes □ no If yes, whom? _____

Have you **ever** seriously considered suicide or felt like harming someone else? □ yes □ no
If yes, please explain: _____

Name of Current Psychiatrist (and phone #): _____

Have you ever had previous therapy/counseling of any kind? □ yes □ no If yes, when, with whom, and for how long?
_____
_____

Have you ever been hospitalized for emotional problems? □ yes □ no Or for substance abuse problems? □ yes □ no
If yes to either of the above, please note when, where, and for how long were you hospitalized? _____
_____
_____

Please check all of the items below that describe your situation:

□ Abuse/trauma – physical, sexual, emotional, neglect
□ Aggression, violence
□ Alcohol use
□ Anger, hostility, arguing, irritability
□ Anxiety, nervousness
□ Attention, concentration, distractibility
□ Career concerns, goals, and choices
□ Childhood issues
□ Codependence
□ Confusion
□ Compulsions and/or obsessions (thoughts or actions that repeat themselves)
□ Decision-making, indecision, mixed feelings, putting off decisions
□ Delusions (false ideas)
□ Dependence
□ Depression, low mood, sadness, crying
□ Divorce, separation, marital conflict, infidelity/affairs
□ Drug use – prescription medications, over-the-counter medications, street drugs
□ Eating problems – overeating, undereating, appetite, vomiting
□ Emptiness
□ Failure
□ Fatigue, tiredness, low energy
□ Fears, phobias
□ Financial or money troubles, debt, impulsive spending, low income
□ Gambling
□ Grieving, mourning, deaths, losses, divorce
□ Guilt
□ Headaches, other kinds of pains
□ Health, illness, medical concerns, physical problems
□ Inferiority feelings
□ Impulsiveness, loss of control, outbursts
□ Irresponsibility
□ Judgment problems, risk taking
□ Legal matters, charges, suits
□ Loneliness
□ Memory problems
□ Mood swings
□ Oversensitivity to rejection
□ Panic or anxiety attacks
□ Perfectionism
□ Pessimism
□ Procrastination, lack of motivation
□ Relationships problems (with friends, with relatives, or at work)
□ School problems
□ Self-centeredness
□ Self-esteem
□ Self-neglect, poor self-care
□ Sexual issues, dysfunctions, conflicts, identity issues
□ Sleep problems (too much, too little, insomnia, nightmares)
□ Spiritual, religious, moral, ethical issues
□ Stress and tension
□ Suspiciousness
□ Suicidal thoughts
□ Temper problems, self-control, low frustration tolerance
□ Thought disorganization and confusion
□ Threats, violence
□ Weight and diet issues
□ Withdrawal, isolation
□ Work problems, employment issues

SUBSTANCE USE HISTORY:

Have you ever experienced a problem with alcohol, drugs, or prescription medications? □ yes □ no

If yes, please explain: _____

_____

_____

_____

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications? □ yes □ no

If yes, please explain: _____

_____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? □ yes □ no If, yes, please explain: _____

_____

Have you had any problems related to use of alcohol/drugs in the past year? □ yes □ no

If, yes, please explain: _____

_____

_____

Has drinking or drug use ever caused you problems in the following areas (check if yes):

□ family □ school □ employment □ legal □ emotional □ social □ financial □ behavior □ physical health

FAMILY BACKGROUND:

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN: □

Names of Children	Living with you?	Age	Grade	School
1. _____	□ yes □ no	_____	_____	_____
2. _____	□ yes □ no	_____	_____	_____
3. _____	□ yes □ no	_____	_____	_____
4. _____	□ yes □ no	_____	_____	_____
5. _____	□ yes □ no	_____	_____	_____

Other than any children already indicated above, who lives in your household? _____

_____

_____

Please describe your relationships with other family members:

Relationship	Living?	Describe quality of relationship
Father	□ yes □ no □ n/a	_____
Mother	□ yes □ no □ n/a	_____
Step-father	□ yes □ no □ n/a	_____
Step-mother	□ yes □ no □ n/a	_____
Spouse/partner	□ yes □ no □ n/a	_____
Sister(s)	□ yes □ no □ n/a	_____
Brother(s)	□ yes □ no □ n/a	_____
Other_____	□ yes □ no □ n/a	_____

Whom were you raised by? _____

Were you adopted? □ yes □ no If so, at what age? _____

What family member(s) were you closest to as a child?
_____
_____

What family members(s) are you closest to now? _____
_____

Check the statement(s) below that describe the type of family you grew up in:

□ overly close family □ no "breathing room" □ everyone was in everyone else's business □ no privacy
□ boundaries not respected □ comfortably close family □ loving □ shared many positive experiences □ supportive
□ distant, everyone did their own thing □ not much time spent together □ not a lot of support □ angry, lots of fighting/hostility
□ verbal abuse and conflicts □ violence □ frightening □ scared to make mistakes

Have any biological relatives ever had any emotional problems or substance abuse? □ yes □ no
If yes, please explain: _____
_____

Has anyone in your family ever attempted or committed suicide? □ yes □ no
If yes, please explain: _____
_____

MARITAL STATUS:
Marital/relationship status (Check one) □ Married; □ Live with partner (check if same ___ or opposite___ sex);
□ Single; □ Separated/Divorced; □ Widowed; or □ Other: _____

Comments regarding stresses in current or previous marriage(s)/relationship(s): _____
_____
_____

If you have had problems in the past, what do you think caused those relationships to end? _____
_____
_____
_____

Have you ever been abused mentally or physically by a romantic partner? □ yes □ no
Does this apply to your current relationship? □ yes □ no
Do you feel safe? □ yes □ no

EMPLOYMENT/EDUCATION INFORMATION:
Check all that apply: □ employed □ retired □disabled □student □ homemaker □ unemployed

If/When employed, what type of work do you do?_____
_____
_____

Current employer is:_____ Years on current job:_____

Your income: _____ Total household income: _____

Highest degree completed in school: _____

HEALTH/MEDICAL INFORMATION:

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____
_____
_____
_____

Do any of these problems affect your everyday life? □ yes □ no If yes, how so? _____
_____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): _____
_____
_____
_____

Have you ever blacked out / lost consciousness and/or experienced any type of serious head injury or trauma? □ yes □ no
If so, please indicate when and what happened.
_____
_____
_____

List all medications that you currently use:

Medication(s) _____
_____
_____
_____

Dosage (amount and times per day) _____

Reason(s)_____

Name of Medication Prescriber: _____

Name of Primary Care Physician (PCP): _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship _____

Address _____
(Street, Apt #) (City) (State) (Zip Code)

Telephone # Daytime _____ Evening _____

Cell Phone_____