Adult Intake History Form

Name: _____ **Date Completed: _____**

Describe what you are wanting help with or what brings you in:

Mark the box beside each concern experienced recently:

- Memories of past events that are haunting
- Nightmares
- Intense reactions to reminders of past events
- Anxiety
- Panic
- Worry
- Depression
- Crying spells
- Lack of motivation
- Difficulties enjoying things
- Low energy
- Problems concentrating
- Memory problems
- Sleeping too much or too little
- Change in appetite or weight
- Difficulty with decisions
- Feeling abandoned
- Feelings of worthlessness or low self-esteem
- Feelings of excessive guilt
- Hopelessness
- Thoughts of suicide
- Self-harm behavior
- Social withdrawal
- Problems with feeling guilty
- Perfectionism
- Feeling misunderstood
- Mood swings
- Racing thoughts
- Irritability
- Angry outbursts
- Restlessness/feeling on edge
- Physical tension
- Social anxiety
- Suspiciousness/Paranoia
- Concerns about drug/alcohol use
- Compulsions
- Specific fears
- Grief/Mourning
- Irrational thoughts
- Hearing strange voices/noises
- Sexual problems
- Eating disorder
- Work problems
- Physical illness
- Frequent physical pain
- Impulsive behavior
- Relationship issues
- Legal difficulties

Enter any additional concerns, symptoms, or details in the space below:

What stressors or life changes have you experienced recently?

What changes do you want to see from therapy – your treatment goals?

1.

2.

3.

4.

Have you seen a therapist in the past? Please provide approximate year, length of treatment, and focus of therapy.

List any past medical, psychiatric, or substance-related hospitalizations (include approximate dates, reason for hospitalization, and the name and location of the hospital):

Your family growing up

	First name	Personality/Mental Health or Substance Use Issues
Mother		
Father		
Sibling		
Sibling		
Sibling		
Other		
Other		

If you need more space for family members:

Mark the box beside each issue you experienced in childhood:

- Happy Childhood
- Physically Abused
- Sexually Abused
- Emotionally/Verbally Abused
- Neglected
- Family Fights
- Drug/Alcohol Use
- Depressed
- Anxious
- Not Allowed to Grow-Up
- Few Friends
- Popular
- Poor Grades
- Good Grades
- "Spoiled"
- Attention Problems
- Moved Frequently
- Weight Problems
- Parents Divorced
- Conflict with Teachers
- Sexual Problems
- Anger Problems

Provide a brief description of any other important childhood experiences or symptoms in your childhood:

Who are the important people in your life now?

What are your current support systems: (e.g., significant others, friends, extended family members, community agencies, religious institutions, etc)

Relationship	First Name	S/he live with you now?	Personality/Mental Health or Substance Use Issues

Relationship History:

How many times have you been married?

How old were you at the time of your marriage(s)?

Briefly describe any problems in your current or past marriages or cohabitation relationships:

Academic & Work History:

Highest level of education completed?

Current job?

hours working per week currently?

Briefly describe any problems in school or employment:

Home Life:

How do you spend personal time? (hobbies, sports, clubs, groups, family activities, etc.)

How many contacts do you have each month with friends outside of work or school?

Who can you talk with about personal feelings or private matters?

Are you satisfied with your romantic life?

Briefly describe any problems in your current romantic relationship or friendships:

Medical Health:

Mark each accident or illness you have experienced

Recent surgery	Head injury
Seizures	Thyroid problems
Drug/alcohol abuse treatment	Neurological disorder
Chronic pain	Headaches
Diabetes	Hormone problems
Infertility	Miscarriages

List any other chronic health problems you have:

How many hours do you sleep in an average night?

How many drinks (containing alcohol) do you consume in an average week?

Which recreational drugs have you used in the last year?

List any prescription or over-the-counter medications you may take, along with the purpose of the medicine:

Do you exercise? How? How often?

Do you use tobacco? How much?

Are you concerned about your physical health?

Accomplishments & Additional Information

List your personal strengths and important accomplishments:

Describe any additional information you think may be of use to Dr. Robinson:

Thanks – Looking forward to learning more about how I might be helpful to you!

Lisa Robinson, Ph.D