HOPELIFE BEHAVIORAL AND WELLNESS SERVICES LLC

ADULT INTAKE FORM

\*\*\*Please note this intake form MUST be completed before your scheduled appointment. Failure to do so will result in your appointment being rescheduled\*\*\*

**Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_**

**Gender: Male DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home number: \_\_\_\_\_\_\_\_\_\_\_\_ May we call and leave a message? Yes**

**Cell number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we text you at this number? Yes**

**How did you hear about Hopelife?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR SEEKING TREATMENT**

**Please briefly describe the reason you are seeking treatment?**

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**What has happened that caused you to seek help now?**

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**What do you hope to achieve as a result of treatment?**

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**How do you handle stress and/or cope with the problems you listed above?**

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**Do you currently have thoughts of harming yourself? No If yes, then for how long?**

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**Do you currently have thoughts wishing you were dead? I don't want to answer**

**Do you currently have thoughts to harm, hurt or kill someone else? No If yes, whom?**

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**Have you *ever* seriously considered suicide and/or harming someone else? No**

**If yes, please explain:**

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**Name and number of current medication provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and number of current therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been hospitalized for mental health problems? No**

**If so, when and for how long?**

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**Please select all items 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 Abuse 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 HISTORY**

**Do you have children? Yes**

**What is your relationship status? single**

**Do you have siblings? Yes If so, how many? \_\_\_\_\_**

**Who in your family has mental health issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Whom do you currently live with?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check off the box that closely describes how you were raised?**

**□** overly close family

□ 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

**Any substance or alcohol abuse in the family? Yes If so, whom?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**EMPLOYMENT/EDUCATION INFORMATION:**

**Are you working? employed**

**Are you seeking disability/SSI? Yes**

**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.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**List all medications that you currently use:**

**Medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dosage (amount and times per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Primary Care Physician (PCP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**