ADULT INTAKE FORM

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Today's date: _____

Demographic Information:

Patient's name:_____
Date of Birth:_____Age:_____
Address:_____
Telephone:(c)_____(email)_____
Ethnicity:_____Country of birth:_____
Languages spoken_____ at what age did you learn second language_____
current percent spoken in each language:____/____
Handedness: Right___ Left___ Ambidextrous___ Gender: Male___ Female___
Any family members left-handed: Yes___ No___

Referral Source:_____
Primary care physician:_____Telephone:_____
Psychiatrist: _____Telephone:_____
Psychologist: _____Telephone:_____

Emergency Contact Information:
Name:_____ Relationship:_____Phone:_____

Presenting Problem (be as specific as you can: describe problems, when did it start...):
_____
_____
_____
_____
_____
_____
Estimate the severity of above problem: ___Mild__Moderate___ Severe__ Very Severe

Academic History:
Did you complete High School? Yes___ No___ What type of grades did you earn?_____
If applicable, list any learning, speech, or behavioral difficulties you had as a child._____
_____
Did you have any attention problems as a child? If yes, please describe._____
Any family history of learning difficulties or attention problems?_____
Did you attend college? Yes___No___ If yes, when _____and for how many years_____

Grades earned _____ what was your major?_____ Did you earn a degree/certificate?
Yes___ No___ If yes, how long did it take you to finish _____
Educational achievement of immediate family members: _____

Employment History:

Please list your current and or past occupations:

Job title or Description	From (mo/yr)	To (mo/yr)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently receiving disability: Yes___ No___
If yes, what type?_____Since when? (mo/yr)_____
Are you currently seeking disability? Yes___ No___
If yes, what type?_____
What is the occupational achievement of your immediate family members?_____
How many times if any have you quit a job without having another job lined up?_____
How many times, if any, have you been fired from a job? _____
Do you do any volunteer work? Yes___ No___ If yes, how many hours a week?_____

Social History:

Are you currently (circle one): Single Partnered Married Divorced Separated Widowed
If divorced or widowed please provide dates: _____
Do you have any children: Yes___ No___
If yes, list names, ages, and any health problems.

_____
Do you have any dependents (children or adults)? _____
Describe your current level of support (Circle one): Excellent Adequate Good Poor
How would you describe your current relationships with your partner, friends and or family?

_____
What are your current living conditions? _____
Do you have a driver's license? Yes___ No___
Are you currently driving? Yes___ No___
What type of transportation do you use (i.e., own car, bus)? _____
Legal history/current legal status (parole, probation, arrests, conviction, divorce, child custody)._

_____
So you have a formulated Advanced Directive/ Conservatorship? Yes ___ No___
If yes, who is the designated Power of Attorney/ Conservator?_____

Describe your recreational activities/hobbies: _____

_____
Describe your strengths:_____

_____

Is spirituality/faith an area of support for you? ____Yes ____No
Religion: ___Catholic ___Christian___Jewish ___Mormon ___Islamic ____Buddhist ___Other
Would you like to receive Christian based counseling when appropriate:
____Yes ____No ____Maybe, please discuss this with me.

Are you involved in any current or pending civil or criminal litigations, lawsuits, divorce or custody disputes: if yes, please explain:_____

_____

_____

Medical History

Any difficulties during pregnancy/birth? No___ Yes _____

Developmental History:

O= On time E = Early D = Delayed

____Crawling ____Sitting____Standing ____Walking ____Talking ____Toilet Training

Did you have any early intervention? (ages 0-3) If yes, please describe:

- Speech/Language Therapy_____
- Occupational Therapy_____
- Physical Therapy_____
- Other _____

Between age 3 and current grade, did you receive any therapies? If so, describe:

_____

_____

Please list any previous hospitalizations and or surgeries beginning with the most recent:

Reason	Date
_____	_____
_____	_____

Please list current and past medications (those for medical and psychological reasons)

Medication	For treatment of:	From (mo/yr)	To (mo/yr)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

History of a head trauma (i.e., MVA, fight, fall)? Yes___ No___

If yes, list date(s) and give a brief description:

Date	cause	length of LOC	Symptoms

_____

_____

Brain Imaging and other Laboratory Results:_____

_____

Any changes with eating/appetite? Yes___ No___ If yes, explain_____

Problems with sleep? Yes___ No___ If yes, any problems with (circle) initiating, maintaining, or early morning awakening. If yes, duration_____How many hours a night of sleep_____

Color blind? Yes___ No___

Vision problems? Yes___ No___ If yes, explain _____

Hearing problems? Yes___ No___ If yes, explain _____

Please list all that currently apply or have applied in the past:

___Allergies
___Arteriosclerosis
___Arthritis
___Blood Disorder
___Cancer or chemotherapy
___Hazardous substance exposure
___High blood pressure
___Diabetes
___Heart disease
___Multiple Sclerosis
___Kidney disease
___Liver disease
___Lung Disease
___Malnutrition
___Polio
___Radiation exposure or therapy
___Thyroid disorder
___Headaches
___Injury to arms, hands, or shoulders
___Past/present drug/alcohol use/abuse

Do you currently smoke? Yes___ No___ If yes, how much per day:_____
If you were previously a smoker, when did you quit?_____
How many alcoholic drinks do you typically consume in a week? _____
Have you ever had problems (with work, social relationships, the law) related to your use of alcohol and or drugs? Yes___ No___

Describe any serious Medical conditions_____
_____

Any family Medical Issues?_____

Any current or past Psychiatric Diagnosis? _____
Please list any psychiatric hospitalizations:

Dates	Diagnosis/Condition	Treatment
_____	_____	_____
_____	_____	_____

Any current or past psychotherapy or psychiatric care? Yes___ No___ (i.e., depression, anxiety).
If yes, why were you treated, dates of service and was it helpful _____
_____
_____
Suicide attempts: No___ Yes,___please include dates and circumstances_____
_____
_____

Any close blood relatives have any history of mental illness (i.e., depression, bipolar disorder, schizophrenia, anxiety disorder, or ADD/ADHD, etc.)_____

Life stressors (circle and or add appropriate stressors): economic, housing, social environment (i.e., recent death of family/friend, poor social support), health problems, transportation problems, occupation, access to health care services, other_____

Behavior and Mood

How would you describe your mood and functional ability most days? (i.e., happy, sad, irritable, etc.).

_____
_____
_____
_____
_____
_____
_____
_____

Please check any of the following symptoms that you are currently experiencing or have experienced in the past, and indicate when these symptoms were present:

	From (mo/yr) to (mo/yr)
___Sad mood, crying or depression	_____
___ Recurrent thought of death or suicide	_____
___Self injurious behavior (cutting or other behavior)	_____
___Mood swings	_____
___Irritability/Anger	_____
___Euphoria (feeling on top of the world)	_____
___Anxiety, nervousness or overwhelmed	_____
___Racing thoughts	_____
___Feeling "panicked" or panic attacks	_____
___Impulsive or reckless behaviors	_____
___Recurrent thought that make you feel anxious	_____
___Repetitive behaviors (e.g., hand washing, checking things) or Mental acts (e.g., counting, repeating words silently)	_____
___Seeing things that other people in the room couldn't see	_____
___Hearing things that other people in the room couldn't hear	_____
___Smelling things that other people in the room couldn't smell	_____
___A feeling that you are being followed or watched	_____
___A feeling that someone is out to hurt or harm you in some way	_____
___Unhealthy eating style (restricting/binge eat)	_____

_____ _____ _____

Client Name (print) Client Signature Date