Office Use Only

Client # ________________

Ins. Dx: _______________

Need Monthly Statement?
□ Yes □ No
EAP □ Yes □ No
□ Individual □ Family

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ADULT INTAKE

Today's Date: _______________

GENERAL INFORMATION – *Please print*

Client Name: Last __________________________ First: __________________________ MI: ________

Mailing Address: ___________________________ City: _________________________ State: ________

Zip: __________ Email: ____

Client's DOB: ______/______/______ SSN: ______-______-______ Age: _____

Marital Status: ________________________ □ Male □Female □Other __________

Racial/ethnic identity: □ American Indian/Alaska Native □ Asian/Asian Indian □Black /African American

□Hispanic/Latino □ Middle Eastern □ Pacific Islander /Native Hawaiian □ White

Home Phone _________________ Can a message be left at this number □ Yes □No

Cell Phone ____________________ Can a message be left at this number □ Yes □No

Responsible Party

Client Name: Last _________________________ First: __________________________ MI: __________

DOB: ______________________

Mailing Address: __________________________ City:___________________________ State: _______

Zip: __________ Phone#: ______________________________

Emergency Contact Information

Emergency Contact: _____________ Phone#:_________________ Relationship: ______________

Referred by: __________________________________ May we thank the person? □ Yes □No

INSURANCE INFORMATION *(if applicable)*

Policyholder's Name: ___________________________ Policyholder's Employer: __________________
Policyholder's DOB (if different from responsible party): __________________________

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ADULT INTAKE

Street Address: ________________________________ City: ________________ State: ___________
Zip ____________

Primary Insurance Carrier: _________________ (Behavioral Health) Phone #:___________________
City: _______________ State: ______ Zip: _______
Member #___________________________ Group #______________________

Secondary Insurance Carrier: _____________________ (Behavioral Health) Phone #:________________
City: __________________ State: ________ Zip: __________
Member #___________________________ Group #______________________

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:
____
____
____

Please check all of the behaviors and symptoms that you consider problematic:

☐ Distractibility	☐ Change in Appetite	☐ Suspicion/paranoia	☐ Hyperactivity
☐ Fatigue	☐ Lack of Motivation	☐ Racing Thoughts	☐ Impulsivity
☐ Withdrawal from people	☐ Excessive Energy	☐ Boredom	☐ Anxiety/worry
☐ Rapid mood swings	☐ Poor memory/confusion	☐ Panic attacks	☐ Sleep problems
☐ Season mood changes	☐ Fear away from home	☐ Nightmares	☐ Sadness/depression
☐ Social Discomfort	☐ Eating Problems	☐ Loss of pleasure/interest	☐ Obsessive thoughts
☐ Gambling problems	☐ Hopelessness	☐ Compulsive behavior	☐ Computer addiction
☐ Thoughts of death	☐ Aggression/fights	☐ Problems with pornography	☐ Self-harm behaviors
☐ Frequent arguments	☐ Parenting Problems	☐ Crying Spells	☐ Irritability/anger
☐ Sexual Problems	☐ Loneliness	☐ Homicidal Thoughts	☐ Relationship problems
☐ Low self-worth	☐ Flashbacks	☐ Work/school problems	☐ Guilt/shame
☐ Hearing Voices	☐ Alcohol/drug use	☐ Visual hallucinations	

☐ Recurring, disturbing memories ☐ Other: ______________________________

What do you consider to be the top 3 stressors in your life?

(a) ________________________________

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ADULT INTAKE

(b) ______________________________
(c) ______________________________

Mood (*past 1-2* weeks) Circle one: Calm Happy Sad Anxious Angry Frustrated Worried Hopeless

Helpless Other: ______________________________

PHYSICAL SYMPTOMS: Circle any that were a problem for you in the last month:

Headaches	*Dizziness*	*Heart Pounding*	*Muscle Spasms*
Muscle Tension	*Sexual Problems*	*Diarrhea*	*Vision Changes*
Numbness	*Tics/Twitches*	*Fatigue Fainting*	*Blackouts*
Chest Pains	*Skin Problems*	*Nausea*	*Chills/Hot Flashes*
Sweating	*Rapid Heart Beat*	*Choking Sensations*	*Stomach Aches*
Shortness of Breath	*Trembling/Shaking*	*Mouth Muscle/Joint Pain*	

RISK ASSESSMENT

	No	Yes	Recently	Today
1. Been so distressed you seriously wished to end your life				
2. Have you had or do you have: a. A specific plan how you would kill yourself?				
b. Access to weapons/means of hurting self?				
c. Made a serious suicide attempt?				
d. Purposely done something to hurt yourself?				
e. Heard voices telling you to hurt yourself				
3. Had relatives who attempted or committed suicide?				
4. Had thoughts of killing or seriously hurting someone?				
5. Heard voices telling you to hurt others?				
6. Hurt someone or destroyed property on purpose?				
7. Slapped, kicked, or punched someone with intent to harm?				

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8. Been arrested or detained for violent behavior?				

Are your problems affecting any of the following?

□ Handling everyday tasks □ Self-esteem □ Relationships □ Hygiene
□ Work/School □ Housing □ Legal matters □ Finances
□ Recreational activities □ Sexual activity □ Health

☐ Yes ☐ No Have you gambled in the past 6 months? If yes, let us know the following
- ☐ Yes ☐ No Have you ever felt the need to bet more and more money?
- ☐ Yes ☐ No Have you ever had to lie to people important to you about how much you gambled?

NUTRITION

Do you purge, restrict, or overeat? Yes/No
Have you had any difficulties or concerns related to food intake? Yes/No

Therapist Notes:

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Partner			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	

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ADULT INTAKE

Children			

Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

□ Parents legally married or living together
□ Parents temporarily separated
□ Parents divorced or permanently separated

□ Mother remarried: Number of times _____
□ Father remarried: Number of times _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional Abuse ☐ Neglect ☐ Lived in a foster home ☐ Sexual abuse
☐ Violence in the home ☐ Multiple family moves ☐ Physical abuse ☐ Crime victim
☐ Homelessness ☐ Parent Substance Abuse ☐ Parent Illness ☐ Loss of a loved one
☐ Teen pregnancy ☐ Placed a child for adoption ☐ Financial Problems

Therapist Notes:

PREVIOUS MENTAL HEALTH TREATMENT

Yes/No		Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

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SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Have you ever had withdrawal symptoms when trying to top using any substances? If yes, please describe: ____

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: ____

Therapist Notes:

MEDICAL INFORMATION

Date of last physical exam: ______________________

Primary Care Provider: ___________________________ PCP Phone# ________________________________

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ADULT INTAKE

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches ☐ Chronic Pain
☐ Surgery ☐ Serious accident ☐ Head injury ☐ Dizziness/fainting ☐ Meningitis
☐ Seizures ☐ Vision Problems ☐ High fevers ☐ Diabetes ☐ Hearing problems
☐ Miscarriage ☐ STD/STI ☐ Abortion ☐ Sleep disorder ☐ Other: ________________

Please list any CURRENT health concerns:
____
____
____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed by

Current over-the-counter medications (including vitamins, herbal remedies, etc.) : ______________________
____

Allergies and/or adverse reactions to medication: ☐ None If yes, please list: ______________________
____

Therapist Notes:

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers
☐ Support/Self-Help Group ☐ Community Group

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☐ Religious/Spiritual Center (which one?)_______________________________

How satisfied are you with the support you receive from your social support network? (Circle One)
Very Unsatisfied   *Un-satisfied*   *Satisfied*   *Very Satisfied*

To which cultural or ethnic group do you belong? ______________________________________
If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _______________
____

How important are spiritual matters to you? ☐ Not at all   ☐ Little   ☐ Somewhat   ☐ Very much

☐ Yes   ☐ No   Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents? _____________________________________
____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): __________________
____

QUALITY OF LIFE

Are you satisfied with your quality of life?
Very Unsatisfied   *Un-satisfied*   *Satisfied*   *Very Satisfied*

What do you do for leisure? ____
Are you able to enjoy leisure/recreational activities?   Yes/No
  If no, why? ____

Therapist Notes:

MISCELLANEOUS INFORMATION

Employment

Employer: ______________________________   Position: ________________________
Length of time in this position: __________   Job Duties: __________________________________
Stress level of this position: ☐ Low   ☐ Medium   ☐ High
Other jobs you have held: ____
____
____
____

How many jobs have you been fired from? ________

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Do you have performance problems or difficulties with your boss? Yes/No

Education

Are you currently attending school? ☐ Yes ☐ No

☐ High School Graduate? Or ☐ GED? Year ___________
☐ Associate's Degree Year ___________ Major area of study ____________________________
☐ Undergraduate Degree Year ___________ Major area of study ____________________________
☐ Graduate Degree Year ___________ Major area of study ____________________________

Military Service

☐ Yes ☐ No Have you been/are you currently in the military? (If no, skip remainder of this section)
Branch____________ Date of Discharge __________ Type of Discharge __________ Rank______________
☐ Yes ☐ No Were you in combat?

Legal

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain
____
____

☐ Yes ☐ No Do you have any pending legal problems? If yes, please explain
____
____
____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain ___
____
____
____

Therapist Notes: