

# ADULT INTAKE FORM

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_  
(Street and Number) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Cell/Other Phone: \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Place of Employment/School: \_\_\_\_\_

Marital Status:  Never Married  Married  Domestic Partnership  Separated  Divorced  Widowed

Name of Spouse/Partner: \_\_\_\_\_ Cell/Other Phone: \_\_\_\_\_

Please list any children/age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?  No  Yes

If yes, previous therapist/practitioner: \_\_\_\_\_

## GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Please list any specific health problems you are currently experiencing:

Please list any prescription medications and dosage that you are currently taking

Name of Prescribing Physician: \_\_\_\_\_

Have you ever been prescribed psychiatric medication?  Yes  No  
If yes, please list and provide dates:

Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? \_\_\_\_\_  
What types of exercise to you participate in:

Please list any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief or depression?  No  Yes  
If yes, for approximately how long? \_\_\_\_\_

Are you currently experiencing anxiety, panic attacks or have any phobias?  No  Yes  
If yes, when did you begin experiencing this? \_\_\_\_\_

Are you currently experiencing any chronic pain?  No  Yes If yes, please describe:  
Do you drink alcohol more than once a week?  No  Yes

How often do you engage recreational drug use?  
 Daily  Weekly  Monthly  Infrequently  Never

Please list any legal issues that may be in progress:

Are you currently in a romantic relationship?  No  Yes  
If yes, for how long? \_\_\_\_\_  
On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

Are you currently employed or in school?  No  Yes  
If yes, what is your current situation? Do you enjoy your work? Is there anything stressful about your current work?

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

### FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	<u>Please Circle</u>	<u>List Family Member</u>
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	