Adult Intake Form

Today's Date: _____

Name:
Birth Date: _____/_____ / _____ Age: _____
Gender Identity: ☐ Male ☐ Female ☐ Intersex ☐ Non-Binary ☐ Other: _____
Preferred Gender Pronoun: ☐ He/his ☐ She/her ☐ They/them ☐ Other: _____
Address/zipcode:
Telephone: Home _____ Work _____ Cell _____
Email Address:
Emergency Contact – Name:_____ Phone Number: _____
Holder of Insurance (if different) Name: Relationship:
Address of Holder (if different):
Referred by (if applicable):
Primary care physician: Contact Number:
Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ Yes ☐ No
Have you had previous professional counseling? ☐ Yes ☐ No If yes, please indicate where you last received counseling:
Are you currently taking prescribed psychiatric medication (i.e. antidepressants or others) ☐ Yes ☐ No If yes, please indicate the name of the medication(s): _____
If no, have you been previously prescribed psychiatric medication? ☐ Yes ☐ No
Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
Have you ever intentionally tried to harm yourself? ☐ Yes ☐ No

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Problem Analysis

1. PROBLEM DESCRIPTION: Briefly describe the problem and symptoms you most wish help with right now:

_____
_
_____
_
_____
_

2. PROBLEM DURATION: a) approximately how long have you had the current problem? _____
b) how would you rate the intensity of the problem or concern that is bringing you in for help? (Circle the appropriate number) 1 2 3 4 5 6 7 8 9

3. PRECIPITATING EVENTS: Were there any precipitating events (e.g. major family illness or death, divorce, moving to a new residence, etc.)?

_____
_____
_____

4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?

_____
_____
_____

5. SLEEP PATTERNS: b. Difficulty falling or staying asleep? Yes/No (if yes, please indicate appropriate description below) ☒ Sleeping too little ☒ Sleeping too much ☒ Poor quality of sleep ☒ Disturbing dreams ☒other please specify: _____

6. Have you noticed (or experienced) any of the following: please check yes or no. If you are able to give a brief description at the end of the section, please do so in the comments section.

	Yes	No
Changes in the amount of sleep?		
Difficulty falling or staying asleep?		
Loss of interest or pleasure in activities?		
Often feeling guilty or worthless?		

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Changes in energy level during the day?		
Changes in concentration?		
Changes in appetite or weight? If there has been a change please indicate increase/decrease amount: _____		
Feeling physically slowed down or lethargic?		
Feeling that life is not worth living?		
Worrying excessively or without any apparent reason?		
Having sudden or intense fear?		
Wanting to hurt someone?		

Feeling in danger for no specific reason?		
Hearing, seeing, or feeling things that do make sense?		
Getting special messages from the television, radio, magazines, etc.?		
Talking a lot more or more rapidly than usual?		
Acting out of character or behaving in ways that are later regretted?		
Feeling more energetic or needing much less sleep than usual?		

If you answered yes to any of the above questions, please elaborate:

_____
_
_____
_

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MEDICAL & HEALTH ISSUES

1. How is your physical health at present? (Please circle response)

Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any persistent physical symptoms, chronic illnesses, or other health concerns (e.g. chronic pain, headaches, fibromyalgia, diabetes, etc.)

_____

_____

_____

3. How many times per week do you exercise? _____ for about how long each time? _____

4. Are you having difficulty with eating habits? Yes/No (If yes, please indicate appropriate response) ☒ Eating less ☒ Eating more ☒ Binging ☒ Restricting ☒ Significant Weight Change (in the last 2 months)

5. Do you regularly use alcohol? Yes/No (If answered yes, please answer questions below.) a)

How often do you use alcohol, and what do you typically drink? _____ b)

Have you used more alcohol or drugs than you intended this year? Yes/No c) Have you ever

felt the need to cut down on the amount of alcohol you drink? Yes/No

d) Do you consider your alcohol consumption a problem? Yes/No/Unsure

6. How often do you engage in recreational drug use? ☒ Daily ☒ Weekly ☒ Monthly ☒ Rarely ☒ Never

Please list any recreational drugs you currently use and how often you use them if applicable:

_____

7. Is there a history or alcohol/substance abuse or dependence in your family? Yes/No (if yes, please specify)

_____

_____

8. Is there a history or mental health concerns or mental illness in your family? Yes/No (if yes,

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please specify)

_____

_____

9. Do you have any problems or worries about sexual functioning? Yes/No (if yes, please indicate appropriate response)

☒ Lack of desire ☒ Performance Problem ☒ Sexual Impulsiveness ☒Difficulties Maintaining Arousal ☒ Worried about STDs (sexually transmitted diseases) ☒ Other please specify:

_____

SOCIAL HISTORY AND OTHER ISSUES

1. Are any family members currently a source of support for you? Yes/No

2. Are any friends currently a source of support for you? Yes /No

3. About how many friends would you describe as close? ☒ None ☒ One ☒ Two or more ☒ Four or more

4. In the past, how would you rate the quality of peer relationships? ☒ Very Poor ☒ Unsatisfactory ☒ Average ☒ Good ☒ Excellent

5. In approximately how many significant intimate relationships (e.g. lasting 6 months or more) have you been involved? _____ Are you currently in one now? Yes/No If yes, please specify current length of relationship: _____ mos/yrs

6. Have you ever experienced sexual abuse, assault, or uncomfortable touching? Yes/No/ Decline to respond

7. Have you had suicidal thoughts recently? Yes/No (if yes, please indicate) ☒ Frequently ☒ Sometimes ☒Rarely ☒ Never

8. Have you had them in the past? Yes/No (if yes, please indicate) ☒ Frequently ☒ Sometimes ☒Rarely ☒ Never

9. Have you ever attempted suicide? Yes/No (if yes, please list age(s) attempt(s))

_____

_

10. Have you ever intentionally inflicted any other form of harm upon yourself? Yes/No

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11. Have you intentionally inflicted any form of harm upon yourself recently? Yes/No

12. Do you currently have any legal concerns or issues pending? Yes/No (if yes, please specify)

_____

_____

Please note any additional information that you feel might be helpful for your counselor to know:

_____

_

_____

_

_____

_

How much did the following problems bother you over the last 2 weeks?

	Not at All	A little	Somewhat	A lot
Nervousness or shakiness				
Feeling sad or blue				
Feeling hopeless about the future				
Feeling everything is an effort				
Feeling no interest in things				
Your heart pounding or racing				
Trouble sleeping				
Difficulty at home				
Difficulty socially				
Difficulty at work or school				

How much do you agree with the following?

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	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel good about myself.				
I can deal with my problems.				
I am able to accomplish the things I want.				
I have friends or family that I can count on for help.				

1. In the past 2 weeks, approximately how many drinks of alcohol did you have? _____ 2. In the past month, how many days were you unable to work because of your physical or mental health? (answer only if employed) _____ days
3. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? (answer only if employed) _____ days
4. In the past month have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
5. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ☐ Yes ☐ No
6. In the past month have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
7. How many times have you seen a doctor in the past six months? ☐ none ☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+
8. Please indicate if you have a serious or chronic medical condition: ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Back Pain or other Chronic Pain ☐ Other condition please specify: _____

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