Your Name____

Intake Forms – Adult

PRESENTING PROBLEM

Please tell us why you are seeking services at this time.____

____

____

What do you hope to accomplish from the services you receive?____

____

SYMPTOM CHECKLIST – Please check all that apply.

Past	Present		Past	Present	
		Addictions			Hopelessness
		Aggressive behavior			Hyperactivity
		Anger			Impulsivity
		Anxiety/worry			Isolation
		Appetite changes			Lack of motivation
		Breaking the law			Learning problems
		Crying spells			Loss/death of a significant person
		Decreased energy			Marital/relationship problems
		Depression			Mood swings
		Developmental disabilities			Physical complaints
		Difficulty concentrating			School problems
		Disobedience			Self-mutilation
		Drugs/alcohol			Sexual problems
		Eating disorders			Sleep changes
		Fears			Speech/language problems
		Fighting			Stress
		Fire setting			Suicidal thoughts
		Hallucinations			Temper tantrums
		Health problems			Wets bed
		Homicidal thoughts			Other:

FAMILY AND SOCIAL INFORMATION

Please list family members and others who are living at your address.

Name	Relationship	Age

Please list any of your children who are not living at your address.

Name	Relationship	Age

Your Name____

Date of Present Marriage______________________ Date of Separation, if applicable______________________
Date of Previous Marriage______________________ Date of Separation/Divorce______________________
Date of Previous Marriage______________________ Date of Separation/Divorce______________________

Please list your family members, including biological and step family members.

Family Member	Name	Age	Marital Status	If deceased, date and cause
Parent				
Parent				
Parent				
Parent				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

How would describe your relationship with your mother?______________________

How would you describe your relationship with your father?______________________

Have you or any family members been physically, emotionally, or sexually abused? If yes, please describe.______________________

Have you ever been a perpetrator of abuse? If yes, please describe.______________________

Is spirituality/religion a part of your life? If yes, please describe.______________________

Who are your main social supports?______________________

EDUCATION INFORMATION

Were you ever diagnosed with a learning or conduct disorder while in school? If yes, please describe.______________________

Were you ever bullied in school? If yes, please describe.______________________

EMPLOYMENT INFORMATION

How long have you been employed in your present job?______________ Length of longest employment______________

What types of jobs have you previously held?______________________

Are you under work/financial stress? If yes, please describe.______________________

LEGAL INFORMATION

Have you ever been arrested? If yes, please describe.______________________

Are you currently on probation or parole? If yes, please describe.______________________

Are you currently involved in any legal actions, such as divorce, bankruptcy, or lawsuit? If yes, please describe.______________________

Have you ever received a DWI or DUI? If yes, please describe.______________________

Your Name____

SUBSTANCE ABUSE INFORMATION

Do you smoke or use tobacco? If yes, how much and how often?____

How many times a week do you drink alcohol?________How many drinks do you usually consume during each occurrence?________

Have you ever felt the need to cut down on your drinking? _____Yes _____No
Have you ever become annoyed at criticism about your drinking _____Yes _____No
Do you ever feel guilty about your drinking? _____Yes _____No
Do you ever need a drink in the morning to get going? _____Yes _____No

Do you or any family members have a history of alcohol and/or drug abuse/dependency? If yes, please describe._________________
____

MEDICAL INFORMATION

Primary Care Doctor_________________________________Phone #____________________Last Exam Date________________

Please list any current and past impairments, illnesses, surgeries, and hospitalizations._______________________________________
____
____

Allergies____

How frequently do you exercise?____

Current Medications

Name of Medication	Dosage	Frequency	Taken As Prescribed?	Date Started	Prescribing Physician	List Any Side-Effects

Please list any current and previous counseling and psychiatric treatment for you and/or any family members.

Individual Receiving Treatment	Type of Treatment (i.e., outpatient, inpatient, residential, chemical dependency, etc.)	Service Provider	Dates

STRENGTHS

Please list some of your strengths and positive qualities.____
____

What hobbies and interests do you enjoy?____
____

Is there anything else you would like us to know?____
____