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INTAKE INFORMATION FORM (ADULT)

NAME: _____ PHONE: _____ DATE OF COMPLETION:_____

BIRTH DATE: AGE: _____ GENDER: ☐ M ☐ F REFERRED BY: _____

MARITAL STATUS: ☐ SINGLE ☐ LIVING TOGETHER ☐ MARRIED ☐ SEPARATED ☐ WIDOWED

HOW LONG? _____

PLEASE DESCRIBE PROBLEMS/CONCERNS FOR WHICH YOU ARE SEEKING HELP:

_____

_____

_____

_____

_____

_____

_____

LISTED BELOW ARE COMMON SYMPTOMS OR EXPERIENCES.
PLEASE CHECK ALL THAT APPLY TO YOU.

PHYSICAL EXPERIENCES FEELINGS

☐ Headaches
☐ Fainting spells
☐ Dizziness
☐ Fatigue/exhaustion
☐ Seizures/convulsions
☐ Blackouts
☐ Visual disturbances
☐ Hearing problems
☐ Dry mouth
☐ Insomnia
☐ Oversleeping
☐ Neck/shoulder pain
☐ Rapid heart rate
☐ Chest pain
☐ Shallow, rapid or "tight" breathing
☐ Back pain
☐ Muscle tension

- [ ] Muscle twitches/tremors
- [ ] Sexual difficulties
- [ ] Bowel disturbances
- [ ] Tingling
- [ ] Numbness
- [ ] Sudden weight changes
- [ ] Marked change in sex drive
- [ ] Stomach trouble
- [ ] Flushes
- [ ] Burning or itchy skin
- [ ] Excessive Sweating
- [ ] Unusually happy/euphoric
- [ ] Agitation; feeling jumpy
- [ ] Sudden changes in mood
- [ ] Feeling bored/disinterested in most activities
- [ ] Overreacting to things
- [ ] Not feeling much of anything
- [ ] Feeling guilty/ashamed
- [ ] Feeling lonely/empty
- [ ] Feeling worthless
- [ ] Feeling hopeless
- [ ] Feeling helpless
- [ ] Feeling discouraged/down in the dumps
- [ ] Nightmares
- [ ] Periods of panic
- [ ] Fear of losing control or going "crazy"
- [ ] Anxious/apprehensive much of the time
- [ ] Frustrated/angry much of the time
- [ ] Suspicious feelings toward others
- [ ] Feeling hungry for approval from others

THOUGHTS

- [ ] Tend to deny problems that others see
- [ ] Difficulty listening to or understanding new ideas
- [ ] Jumping from thought to thought, with no apparent connection between thoughts
- [ ] Thoughts going too fast/slow
- [ ] Mind goes blank
- [ ] Difficulty making decisions
- [ ] Overly self-conscious
- [ ] Tend to focus on the past
- [ ] Tend to see people and events in a negative light
- [ ] Hearing things with no apparent cause
- [ ] Seeing things with no apparent cause
- [ ] Self-critical thoughts
- [ ] Difficulty concentrating
- [ ] Amnesia, inability to remember periods of your life

- [ ] Confusion
- [ ] Constantly comparing yourself to others
- [ ] Believing that your thoughts cause things to happen
- [ ] Worrying about your health
- [ ] Having unwanted thoughts again and again
- [ ] Painful or unwanted memories
- [ ] Thoughts about hurting yourself
- [ ] Thoughts of suicide
- [ ] Destructive fantasies or images
- [ ] Believing that people are generally vindictive

BEHAVIORS

- [ ] Marked change in activity level
- [ ] Doing dangerous activities
- [ ] Poor performance at work
- [ ] Dishonest behavior: lying/stealing
- [ ] Use drugs/alcohol to feel better
- [ ] Overeating/undereating
- [ ] Often in a hurry
- [ ] Marked change in pattern of eating
- [ ] Focusing too much on some parts of life and neglecting others
- [ ] Angry outbursts, aggressive or destructive behavior
- [ ] Nervous behaviors (can't sit still, nail biting, etc.)
- [ ] Self-harming behavior
- [ ] Impulsive behavior
- [ ] Behavior inconsistent with your personal values
- [ ] Repeating certain acts again and again
- [ ] Trying to do things perfectly
- [ ] Staying up too late at night
- [ ] Not showing up for work/arriving late
- [ ] Difficulty getting out of bed in the morning
- [ ] Procrastination: avoiding or putting off things that need to be done

RELATIONSHIPS

- [ ] Difficulty relating to others at work: e.g., a supervisor, supervisee, or co-worker
- [ ] Difficulty relating to family members/relatives
- [ ] Difficulty relating to spouse/significant other
- [ ] Relying on others to make your decisions or take care of you
- [ ] Withdrawing from others/isolating yourself
- [ ] Engaging in sexual behavior you don't like
- [ ] Letting others take advantage of you
- [ ] Difficulty expressing feelings
- [ ] Try too hard to please others
- [ ] Difficulty building friendships or relating to friends
- [ ] Difficulty with your sexual life
- [ ] Difficulty listening to others

☐ Nag others or frequently criticize others
☐ Act phoney; not being yourself
☐ Verbally attack or blame others
☐ Physically fight with others

TRAUMATIC EXPERIENCES

Have you ever experienced any of the following: ☐ YES ☐ NO
If yes, please check all that apply.

☐ Crime victim
☐ Combat
☐ Assault
☐ Rape
☐ Near death experience
☐ Loss of a loved one
☐ Physical or sexual abuse
☐ Loss of job
☐ Miscarriage(s)
☐ Accident (physical injury)
☐ Recent diagnosis of chronic or terminal illness(es)
☐ Other _____

Have you ever seen a therapist or counselor regarding these or any other concerns? ☐ YES ☐ NO
If yes, when? _____

HISTORY

Name of spouse or significant other: _____
Describe your present relationship with your spouse or significant other:

_____

_____

_____

Any previous marriages/divorces? ☐ YES ☐ NO If yes, please describe: _____

_____

Have you ever had marital counseling ☐ YES ☐ NO If yes, describe when and outcome:

_____

_____

Do you have children? ☐ YES ☐ NO
Do you have custody of them? ☐ YES ☐ NO

List your children in the order of birth, including deceased:

Name	Age	Residence	Occupation	Health
1				
2				

3 _____
4_____
5_____

Have you had any other pregnancies? _____
Describe your present relationship with your children _____
_____
_____
_____

Living situation — where are you currently living and with whom? _____
_____

Is there anything about your current living situation that is a concern at the present time? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

Educational status: _____ Occupation_____

FAMILY HISTORY
FATHER'S NAME _____
Is your father living ☐ YES ☐ NO Present age _____ Deceased age _____
Current health status: _____
Cause of death: _____
Describe father's personality and your relationship with him: _____
_____
Educational status: _____ Occupation _____

MOTHER'S NAME
_____
Is your mother living ☐ YES ☐ NO Present age _____ Deceased age _____
Current health status: _____
Cause of death: _____
Describe mother's personality and your relationship with her: _____
_____
Educational status: _____ Occupation _____
Describe your parents' relationship with each other: _____
Describe your present relationship with your parents: _____

Siblings: List your siblings, in order of birth, including deceased:

Name	Age	Residence	Occupation	Health
1				
2				
3				

4_____
5_____

Describe your present relationship with your siblings: _____
_____
_____

Do you have any concerns about relationships with family members or in-laws? ☐YES ☐NO
If yes, please describe: _____
_____
_____

Briefly, how would you describe your childhood? _____
_____
_____

Are you in a relationship where you are physically hurt, threatening, or made to feel afraid?☐YES☐NO
If yes, please describe: _____
_____
_____

Have you ever experienced any physical, verbal, or emotional abuse or neglect in your family or in any other relationship? ☐YES ☐NO If yes, please describe: _____
_____
_____

Was the abuse or neglect reported ☐YES ☐NO If yes, please describe: _____
_____
_____

If so, was the abuse reported ☐YES ☐NO If yes, please describe: _____
_____
_____

Have you ever been sexually abused within your family or outside of the family? ☐YES ☐NO
If yes, please describe: _____
_____
_____

HEALTH HISTORY
Did you experience any significant childhood illnesses? ☐YES ☐NO
If yes, please describe: _____
_____
_____

Please give a history of past hospitalizations and/or surgeries: _____

_____
_____

Do you have any current medical problems? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

Have your physical problems caused you to see different doctors? ☐ YES ☐ NO

If yes, have these doctors had trouble finding what caused these physical problems? ☐ YES ☐ NO
Do you have a family doctor? ☐ YES ☐ NO
Doctor's Name _____ Date last seen _____
Are you taking any medications? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

If female, do you have any problems or concerns with your menstrual cycle? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

What is your present weight? _____Height _____
Have you experienced a change in appetite in the last year? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

Have you experienced a significant weight loss or weight gain in the last year? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

Are you comfortable with your present weight? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

What do you feel would be an ideal weight for you? _____
Have you ever severely restricted your diet, induced vomiting, or used laxatives or diet pills to lose weight? ☐ YES ☐ NO If yes, please describe: _____
_____
_____

Do you exercise ☐ YES ☐ NO If yes, please describe: _____
_____
_____

Do you use tobacco products ☐ YES ☐ NO If yes, what kind:_____

_____

_____

How much? _____ how long? _____
Do you drink beverages containing caffeine? ☐ YES ☐ NO If yes, what kind: _____

_____

_____

How much? _____ How often? _____
Have you in the past or are you currently using any mood altering chemicals? ☐ YES ☐ NO
If yes, describe how much and how often _____

_____

_____

Wine	How much? _____	How often _____
Beer	How much? _____	How often _____
Hard liquor	How much? _____	How often _____
Marijuana	How much? _____	How often _____
Barbiturates (downers)	How much? _____	How often _____
Stimulants (cocaine, crack, speed)	How much? _____	How often _____
Tranquilizers	How much? _____	How often _____
Hallucinogens (LSD, acid, mushrooms)	How much? _____	How often _____
Inhalants (sniffing glue, gas, etc.)	How much? _____	How often _____
Narcotics (heroin, codeine)	How much? _____	How often _____
Other		

_____

Do you have any concerns about your drinking or drug use? ☐ YES ☐ NO
If yes, what kind: _____

_____

_____

Have your family members or friends commented on your drinking or drug use? ☐ YES ☐ NO
If yes, please describe: _____

_____

_____

Have you experienced any problems in your job, family, or relationships because of your chemical usage? YES NO If yes, what kind: _____

_____

_____

Have you ever passed out when drinking? ☐ YES ☐ NO
History of blackouts? ☐ YES ☐ NO
Have you ever experienced shakiness, hallucinations, or DT's? ☐ YES ☐ NO
History of legal problems related to chemical usage? ☐ YES ☐ NO
Have you ever been to AA, NA, or Alanon? ☐ YES ☐ NO
Have you ever had a problem with any type of gambling? ☐ YES ☐ NO
If yes, please describe: _____

_____

_____

EDUCATIONAL BACKGROUND

Highest level of education completed: _____
Any specialized training? _____
Any problems with reading, writing, or learning? _____
While you were in school, did anyone ever say that you were a slow learner? ☐ YES ☐ NO

VOCATIONAL AND FINANCIAL

List your current or most recent place of employment:
Occupation: Length of time employed:
Do you like your work? ☐ YES ☐ NO Explain _____
_____

List significant other jobs and length of employment in the past five years:
Spouse's vocation:
Do you have any financial concerns? ☐ YES ☐ NO

LEGAL BACKGBOUND

Do you have any current legal issues pending? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____

Any past history of legal difficulties? ? ☐ YES ☐ NO
If yes, please describe: _____
_____
_____
_____
_____

WHAT ARE YOUR HOPES AND EXPECTATIONS OF THERAPY?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____