Adult Intake

Name: _____ Date of Birth: _____

Preferred Name: _____ Preferred Pronoun: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ ____ Permission to leave a message

Secondary Phone: _____ ____Permission to leave a message

Email for appointment reminders: _____

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone: _____

Strengths

_____
_____
_____

Supports

_____
_____
_____

Weaknesses/Needs

_____
_____
_____

Reason for Seeking Therapy

_____
_____
_____

Medical History

PCP: _____

Please list any medical conditions/surgeries:

_____
_____
_____
_____

Are you prescribed any medications? ____Yes ____No

If yes, please provide details:

Medication	Dose	Frequency	Reason

Do you have any sleep difficulties?

___ Difficulties falling asleep ___ Difficulties staying asleep ___ Difficulties waking up
___ Other:_____

Do you have any concerns with your eating habits? ___Yes ___No

If yes, please provide details:

_____
_____

Drug and Alcohol History

Do you currently use tobacco products?

___Yes ___No Frequency:_____

Do you currently drink alcohol?

___Yes ___No Frequency:_____

Do you currently use recreational substances?

___Yes ___No Frequency:_____

Treatment History

Have you previously received any mental health services (outpatient, medication management, marriage or family counseling, inpatient, etc.)? ____Yes ____No

If yes, please provide details:

Service	Provider	Contact	Dates

Are you prescribed any psychiatric medications? ____Yes ____No

If yes, please provide details:

Medication	Dose	Frequency	Reason Prescriber

Social/Family History

Do you have any family members or relatives that have a history of mental health diagnosis? Please provide details of the relationship and diagnosis:

_____
_____
_____

Is there a history of suicide in the family? Please provide details of the relationship:

_____
_____
_____

Do you have a history of suicidal thoughts? ___Yes ___No Frequency:_____

Do you have a history of suicide attempts? ___Yes ___No

Describe:

_____
_____
_____

Do you have current suicidal thoughts? ___Yes ___No Frequency:_____

Do you have a plan? ___Yes ___No

Describe:

_____
_____
_____

Do you have a history of homicidal thoughts? ___Yes ___No
Frequency:_____

Do you have any current homicidal thoughts? ___Yes ___No
Frequency:_____

Do you have a plan? ___Yes ___No

Describe:

_____
_____
_____

Do you have access to any weapons? ___Yes ___No

Are weapons locked or secured? ___Yes ___No

Please mark any of the following that apply to you:

___Abuse (Emotional, Physical, Sexual, etc.)
___Anger
___Anxiety
___Body image issues
___Depression
___Extreme stress
___Hallucinations
___Mood swings
___Nightmares
___Obsessive thoughts
___Panic attacks
___Phobias
___Relationship issues
___Self injury
___Trauma
___ Other _____

Who lives in your home?
_____
_____

How would you describe your home life?
_____
_____

Please list any significant life changes in the past year:
_____
_____
_____

Education

Are you currently in school? ___Yes ___No

Program: _____

What is your highest level of education? _____

Employment

Are you currently employed? ___Yes ___No
Where?_____

How long have you been at your current job?

_____

Are you currently happy with your current position? ___Yes ___No

Legal

Do you have any current charges or legal cases that are active?

_____
_____

Are you currently on probation/parole:

_____

Have you ever been convicted of a crime? Please provide details of the charges and when:

_____
_____
_____

Spiritual/Religious

Do you have any spiritual/religious beliefs?

_____

Would you like these beliefs incorporated into your sessions?

_____
_____

Sessions

Please list anyone that may participate in sessions with you and their relationship to you:

_____
_____

Please list any goals that you want to work on during sessions:

_____
_____
_____
_____

Any additional information you would like to share: