Adult Intake Assessment Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Today's Date:_____

General Information

Name: _____

(Last) (First) (Middle Initial) (Preferred)

Name of parent/guardian (if under 18 years)

_____

(Last) (First) (Middle Initial)

Date of Birth: _____/_____/_____ Gender: [ ] Male [ ] Female

Address: Street and Number _____

City, State, Zip _____

Phone: Home - _____ Cell - _____

May we leave messages? [ ] Yes [ ] No

Email address: _____

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

Referred by (if any): _____

Demographic Information

Race: _____ Language: _____

Ethnicity: _____ Religion: _____

Cultural Considerations: _____

Education

High School: _____

(School) (Last Grade Completed) (Graduated? Y or N)

Post High School Education: _____

(School) (Last Grade Completed) (Graduated? Y or N)

Is or was school performance a concern for you? If yes, please explain:

_____

_____

Marital Status

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Other

Years Married: _____ Years Divorced: _____

Are you currently in a romantic relationship? [ ] Yes [ ] No If yes, for how long? _____

On a scale of 1-10 (10 being the best) how would you rate your relationship? _____

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

_____

_____

Children:

(Name) (Age) (Sex) (Grade/Occupation) (Living at home) (Biological, Adopted, or Step)

_____

_____

_____

_____

_____

Other household members currently living in the home with you:

(Name) (Age) (Sex) (Grade/Occupation) (Relationship to you)

_____

_____

_____

_____

_____

Health History

Primary Physician: _____

Primary Physicians Phone: _____ Date of last exam: _____

List any Allergies: _____

List any previous surgeries: _____

Are you currently taking any medications? [ ] Yes [ ] No If Yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? [ ] Yes [ ] No If Yes, please list:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health?

[ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent

Please list any specific problems you are currently experiencing:

_____

_____

How would you rate your current sleeping habits?

[ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent

Please list any sleep problems you are currently experiencing:

_____

_____

How many times a week do you generally exercise? _____

What types of exercise do you participate in? _____

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

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? [ ] Yes [ ] No

If Yes, approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? [ ] Yes [ ] No

If Yes, approximately how long? _____

Are you currently experiencing any chronic pain? [ ] Yes [ ] No
If Yes, where and how long? _____
Are you currently experiencing any physical characteristics or body image concerns? [ ] Yes [ ] No
If Yes, please explain? _____
Is sexual functioning an area of concern for you? [ ] Yes [ ] No
If Yes, please explain? _____

Substance Abuse

Do you drink alcohol more than once a week? [ ] Yes [ ] No If yes, how often? _____
Is alcohol an area of concern for you? [ ] Yes [ ] No If yes, please explain? _____
How often do you participate in recreational drug use? [ ] Daily [ ] Weekly [ ] Monthly [ ] Never
Is recreational drug using an area of concern for you? [ ] Yes [ ] No If yes, please explain? -

_____

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.):

	Please check	List family member
Alcohol/Substance abuse	[ ] Yes [ ] No	
Anxiety	[ ] Yes [ ] No	
Depression	[ ] Yes [ ] No	
Domestic Violence	[ ] Yes [ ] No	
Eating Disorders	[ ] Yes [ ] No	
Obesity	[ ] Yes [ ] No	
Obsessive Compulsive Disorder	[ ] Yes [ ] No	
Schizophrenia	[ ] Yes [ ] No	
Suicide Attempts	[ ] Yes [ ] No	

Abuse History

Have you ever experienced physical, sexual, or emotional abuse? [ ] Yes [ ] No If yes, please explain:

_____

Legal History

Do you have a history on any legal charges? [ ] Yes [ ] No If yes, please explain:

_____

Are you currently on probation or parole? [ ] Yes [ ] No If yes, please explain:

_____

Is treatment court ordered? [ ] Yes [ ] No If yes, please explain:

_____

Employment

Are you currently employed? [ ] Yes [ ] No If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____