Adult Intake Form
General Information

Name:_____

Date of Birth: ____/____/____ Age: _____ Gender: _____

Address:_____

_____

Phone Number (Day): _____ Phone Number (Evening): _____

Primary Care Physician: _____

Highest Level of Formal Education: _____

Current Occupation: _____

Family Information:

Relationship	Name	Age	Gender	Highest level of education	Occupation
Mother					
Father					
Partner					
Children					

Marital Status: Single / Engaged / Married / Separated / Divorced / Remarried / Living Together

If married, date of marriage: _____
If divorced, date of divorce: _____
*If divorced and have children with partner, who has legal custody of the child(ren)?

_____

Please describe the custody arrangements: _____

_____

Health:

Please list all major illnesses, injuries, surgeries, accidents, or other medical conditions that you have experienced:

Dates	Incident	Treating Physician

Please list all mental health services that you have received:

Dates	Reason	Therapist/Psychologist

Please list all psychological or psychiatric hospitalizations that you have been to:

Dates	Reason	Hospital

Please list any prescription medications that you are currently taking:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				School days 7 days As needed	
				School days 7 days As needed	
				School days 7 days As needed	
				School days 7 days As needed	

Please describe any side effects from the medications:

Current Reasons for Seeking Treatment:

Please describe the reasons that you are seeking treatment at this time:

Please describe how these concerns have been affecting your relationship with your family:

Please describe how these concerns have been affecting your relationship with your friends:

Please describe how these concerns have been affecting your functioning at school/work:

Please describe the things that you tried that has helped you to feel better:

Please describe the things about yourself that you feel proud of:

Instructions: In the spaces below complete the rating at the end of each by marking an "X" on the lines at the points that describe how much your current challenges affect each area and *whether you need treatment or special services for the challenges*.

1a. How your challenges affect your relationship with friends.

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

1b. How your challenges affect his or her relationship with brothers or sisters
(if no siblings, check here _____and skip to #2)

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

2. How your challenges affect your relationship with your parent(s).

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

3. How your challenges affect your academic progress at school

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

4. How your challenges affect your self-esteem

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

5. How your challenges affect your family in general

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

6. Overall severity of your challenges in functioning and overall need for treatment.

No Problem
Definitely does not need treatment or special services

Extreme Problem
Definitely needs treatment or special services

Please circle the degree to which you have been experiencing each of the following MOODS, EMOTIONS, and FEELINGS:

	Not At All	To Only A Mild Degree	To a Moderate Degree	To A Very Strong Degree
1. Angry	0	1	2	3
2. Paniky	0	1	2	3
3. Depressed	0	1	2	3
4. Ashamed	0	1	2	3
5. Bored	0	1	2	3
6. Irritable	0	1	2	3
7. Fearful	0	1	2	3
8. Suspicious	0	1	2	3
9. Empty	0	1	2	3
10. Lonely	0	1	2	3
11. Resentful	0	1	2	3
12. Dependant	0	1	2	3
13. Confused	0	1	2	3
14. Guilty	0	1	2	3
15. Nervous	0	1	2	3
16. Listless	0	1	2	3
17. Hopeless	0	1	2	3
18. Tense	0	1	2	3
19. Sad	0	1	2	3
20. Mistrustful	0	1	2	3
21. Terrified	0	1	2	3
22. Embarrassed	0	1	2	3
23. Elated	0	1	2	3
24, Abandoned	0	1	2	3
25. Agitated	0	1	2	3
26. Worried	0	1	2	3
27. Helpless	0	1	2	3
28. Grief	0	1	2	3

Other Moods, Emotions or Feelings not noted above:

Please circle how often you have been bothered by each of the following difficulties with THINKING:

	Never	Occasionally	Often	Very Often
1. Concentration difficulties	0	1	2	3
2. Difficulty remembering things	0	1	2	3
3. Your mind going "blank"	0	1	2	3
4. Difficulty making decisions	0	1	2	3
5. Difficulty making sound judgments	0	1	2	3
6. Distractible	0	1	2	3
7. Thoughts are "racing"	0	1	2	3
8. Unwanted and/or intrusive thought(s), image(s), or urge(s)	0	1	2	3
9. Repetitive thought(s), image(s), or urge(s)	0	1	2	3
10. Suicidal Thoughts	0	1	2	3
11. Thoughts of Killing Someone	0	1	2	3
12. Preoccupation with Death	0	1	2	3

Other concerns not noted above:

Please circle how much you have been bothered by each of the following PHYSICAL REACTIONS:

	Never	Occasionally	Often	Very Often
1. Shortness of breath or smothering sensations	0	1	2	3
2. Nausea, diarrhea, or other abdominal stresses	0	1	2	3
3. Trouble swallowing or "lump in throat"	0	1	2	3
4. Muscle tension, aches, or soreness	0	1	2	3
5. Flushes (not flashes) or chills	0	1	2	3
6. Dizziness or light-headed	0	1	2	3
7. Trouble falling or staying asleep	0	1	2	3
8. Sweating or cold clammy hands	0	1	2	3
9. Fatigue or loss of energy	0	1	2	3
10. Decrease in appetite	0	1	2	3
11. Weight loss	0	1	2	3
12. Decreased need for sleep	0	1	2	3
13. Numbness or tingling sensations	0	1	2	3
14. Weepiness/crying	0	1	2	3
15. Palpitations or accelerated heart rate	0	1	2	3
16. Headaches	0	1	2	3

	Never	Occasionally	Often	Very Often
17. Increase in appetite	0	1	2	3
18. Weight gain	0	1	2	3
19. Increased need for sleep	0	1	2	3
20. Chest pains or discomfort	0	1	2	3
21. Physical problems (for example, impaired physical functioning, physical pain, etc.)	0	1	2	3
22. Awakening earlier in the morning than you normally do.	0	1	2	3

Other Physical Reactions not noted above:

Please circle how much you have been experiencing each of the following reactions:

	Never	Occasionally	Often	Very Often
1. Feeling as if things were not real	0	1	2	3
2. Feeling little or no interest in things	0	1	2	3
3. Feeling little or no pleasure from activities	0	1	2	3
4. Having nightmares or distressing dreams	0	1	2	3
5. Problems with sexual functioning	0	1	2	3
6. Feeling detached from (as if an observer of) your own mental processes or body	0	1	2	3
7. Feelings of inadequacy or worthlessness	0	1	2	3
8. Feelings like you want to beat or harm someone	0	1	2	3
9. Wanting to avoid certain things, places, people, or activities	0	1	2	3
10. Social withdrawal	0	1	2	3
11. Temper outbursts	0	1	2	3
12. Excessively checking things, counting things, washing, or other repetitive action(s) that you feel you must perform	0	1	2	3
13. Having strange and peculiar experiences (for example: hearing voices, seeing shadows or images, etc.)	0	1	2	3

Please place a checkmark in the appropriate box for each of the following.

Have you ever:	Present	Past	Never
1. Purposely injured yourself without suicidal intent (e.g., cut, hit, burned, etc.)			
2. Seriously considered attempting suicide			
3. Made a suicide attempt			
4. Considered seriously injuring another person			
5. Intentionally caused serious injury to another person			
6. Had unwanted sexual contact(s) or experience(s)			
7. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)			
8. Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g., friend, family, partner, or authority figure) with cruel or malicious intent)			

Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used in Last 48 Hours	Used in Last 6 Months
Alcohol					Y N	Y N
Nicotine					Y N	Y N
Marijuana					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N

Over the past 6 months, how many times has each of the following happened to you <u>because of your substance use</u>?

	Never	Once	Twice	3-4 times	5 or more times
1. You've gotten in trouble with someone you are dating/your partner					
2. You've had problems at school or with schoolwork					
3. You've had problems with friends					
4. You've have been in trouble with the police					