ADULT PSYCHOTHERAPY INTAKE FORM

Please provide the following information. All information will be protected and held confidential.

Name:____
(Last) (First) (Middle Initial)

Preferred name: ___________________________________

Age:__________ **Birthdate:**__________ **Gender:** M F Other

Relationship Status: Never Married Married Divorced Separated Widowed
Domestic Partnership

Please list any children, alive or deceased, and ages:

____

____

____

____

Home Address:

____
(Street) (City) (State) (ZIP)

Primary Phone #:_______________________________ Home Cell Work

Okay to leave a message? Yes No

Email: ____

Emergency Contact:____
(Name) (Relation) (Phone)

Referred by (ex: physician, friend, etc.):____

Medical Information

Have you previously participated in or received mental health services (ex: psychiatric care, individual counseling, group therapy and/or substance abuse treatment)? Yes No

If yes, what types of services and approximately when?

____

____

____

How would you describe your current physical health (please circle one):

Poor *Unsatisfactory* *Satisfactory* *Good* *Excellent*

Please list any current medical conditions:

____

____

____

Please list any medications you are currently taking (including prescription, over the counter, supplements):

____

____

____

How often, on average, do you consume a drink containing alcohol?

Never

Monthly or less

2-4 times a month

2-3 times a week

4 or more times a week

Check any of the following that you have used in the past year:

Marijuana

Cocaine

Non-prescription pain medication

Heroin

Methamphetamine Other:______________________________

If you use nicotine, have you been thinking about quitting? Yes No

Check any of the following you have experienced in the past 60 days:

Hospitalization for severe stress or suicidality

Loss of interest in previously enjoyed activities

Overwhelming sadness

Crying spells

Significant change in weight

Problems in your relationships with friends or family

Overwhelming anxiety, nervousness, worry, or fear

Sudden unexpected panic spells

Frequent physical complaints (headaches, pain, etc)

Intrusive unwanted thoughts or images

Sleep changes and/or difficulties

Racing thoughts

Sexual concerns

Thoughts of suicide

Irritability or easily frustrated

Concerns related to sexual or gender identity

Mood swings

Grief

Overspending

Self-injury (i.e. cutting, burning, etc.)

Family History

Please check any issues that currently exist or have existed within your family:

Condition:	Family Member(s):
Depression	____________________
Bipolar disorder	____________________
Anxiety	____________________
Alcohol/Drug Abuse	____________________
History of suicide attempts	____________________
Eating disorder	____________________
Schizophrenia	____________________

Social History

Are you currently employed? Yes No

If yes, what is your current employment?____

Rate your job satisfaction on a scale from 1-10 (with 10 being fully satisfied):_______________

Are you currently in a romantic relationship? Yes No

If yes, how long have you been in your current relationship?_________________________________

Rate your relationship satisfaction on a scale of 1-10 (with 10 being fully satisfied):______________

Do you currently live alone? Yes No

If no, please list relationship to other household members (for example, my partner, my uncle, my children, roommates, etc.):____

____

Do you consider yourself a spiritual person? Yes No

Do you have a religious affiliation? Yes No

If yes, please specify?____

Have you experienced any life changes or stressful events recently?

____

____

____

____

What do you hope to be different about you or your life by the end of therapy ?

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