Adult Intake Form + Psychosocial

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.

Name:_____

(Last) (First) (Middle Initial)

Birth Date: _____ Age: _____ Gender: _____

Marital Status:

___Never Married ___Domestic Partnership ___ Married (Name of Spouse): _____

___Divorced ___Widowed ___Separated

____Number of pregnancies ____ Number of live births ____ Number of living children

Please list living children/age: _____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) May we leave a message: ___ Yes ___ No

Cell/Other Phone: ( ) May we leave a message: ___ Yes ___ No

Email:_____ May we email you? ___ Yes ___ No

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

Referred by (if any): _____

Insurance Information:

Member ID or SSN: _____ Plan Name: _____

Group Number: _____ Service Phone Number (back of card): _____

Subscriber/ Policy Holder Name:_____ DOB: _____

Subscriber Address: _____

Subscriber Phone Number: _____ Relationship to Client: _____

PRESENTING PROBLEM: (Briefly describe the issues/problems which led to your decision to seek therapy services).

_____

_____

_____

How severe, on a scale of 1-10 (with 1 being the most severe), **do you rate your presenting problems?**

LEAST SEVERE 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ MOST SEVERE

PRESENTING PROBLEM CATEGORIZATION: (Please check all that apply and circle the description)

Symptoms causing concern, distress or impairment:

☐ **Change in sleep patterns** (*please circle*): ☐ sleeping more ☐ sleeping less ☐ difficulty falling asleep ☐ difficulty staying asleep ☐ difficulty waking up ☐ difficulty staying awake

☐ **Concentration:** ☐ Decreased concentration ☐ Increased or excessive concentration

☐ **Change in appetite:** ☐ Increased appetite ☐ Decreased appetite

☐ **Increased Anxiety** (describe): _____

☐ **Mood Swings** (describe):_____

☐ **Behavioral Problems/Changes** (describe):

_____

_____

☐ **Victimization** (*please circle)*: ☐ Physical abuse ☐ Sexual abuse ☐ Psychological Abuse ☐ Robbery victim ☐ Assault victim ☐ Dating violence ☐ Domestic Violence ☐ Human trafficking ☐ UI/DWI crash ☐ Survivor of homicide victims

Other: _____

Other (Please describe other concerns): _____

_____

How long has this problem been causing you distress? (please circle)

☐ One week ☐ One month ☐ 1-6 Months ☐ 6 Months – 1 Year ☐ Longer than one year

How do you rate your current level of coping on a scale of 1 – 10 (with 10 being unable to cope)?

ABLE TO COPE 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ UNABLE TO COPE ☐

FAMILY COMPOSITION:

Marital status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in your household.

Name	Gender	Age	Relationship To Client	Living with you
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

What else do you feel/believe would be helpful, or important for us to know/understand about your relationships with your family or about your family members?

_____

_____

RECENT LOSSES:

☐ Family Member ☐ Friend ☐ Health ☐ Lifestyle ☐ Job ☐ Income ☐ Housing ☐ None

Who? _____ When? _____ Nature of Loss? _____

Other Losses: _____

Additional information (if needed):

_____

_____

PREGNANCY & BIRTH HISTORY:

Were there any complications during **your** pregnancy ☐ Yes ☐ No ☐ Not Applicable

If yes, please explain:

_____

_____

☐ Full-term Birth ☐ Premature Birth

Were there any complications during **your** birth (with your child)? ☐ Yes ☐ No If yes, please explain:

_____ _____

Were drugs or alcohol consumed during pregnancy? ☐ Yes ☐ No

Weight at birth? _____ lbs. _____ oz. Health at birth? _____

Length of hospital stay. _____ Post-partum depression? ☐ Yes ☐ No

Were there any complications while your **biological mother/parent was pregnant** with you? ☐ Yes ☐ No

If yes, please explain:

_____

_____

☐ Full-term Birth ☐ Premature Birth

Were there any complications with your mother/parent during your birth? ☐ Yes ☐ No

If yes, please explain: _____

_____

Were drugs or alcohol consumed during pregnancy? ☐ Yes ☐ No

Weight at birth? _____ lbs. _____ oz. Health at birth? _____

Length of hospital stay. _____ Post-partum depression? ☐ Yes ☐ No

Were you adopted? ☐ Yes ☐ No If yes, at what age? _____

☐ Domestic adoption ☐ International adoption (Country: _____)

DEVELOPMENTAL HISTORY:

As accurately as you can remember, how old were you when you:

Rolled over? _____ Crawled? _____ Walked? _____ Talked (two words)? _____ Toilet Trained? _____

Were there concerns about your development in any of these areas (below)?

☐ Speech/Language ☐ Motor Skills ☐ Cognitive/Intellectual ☐ Sensory ☐ Behavioral ☐ Emotional ☐ Social

If so, please describe: _____

_____

Were there any significant disturbances/changes during your childhood? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

HEALTH HISTORY

How would you describe your overall health? _____

Do you have any health issues? ☐ Yes ☐ No If yes, please list below: _____

_____

Do you have any recurrent medical conditions such as ear infections, asthma or allergies? ☐ Yes ☐ No

If yes, please explain: _____

Do you have tubes in your ears/ or have had them in the past? ☐ Yes ☐ No

Include current significant medical problems (physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.)

Medical Conditions	Currently Receiving treatment?	Provider	Does this condition cause stress or impairment currently?	What have you found that helps?

Do you take any medications? ☐ es ☐ No

Please list medications (including psychotropic, over the counter, herbal remedies) that you have taken in the

past 6 months

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Are you taking the medications as prescribed? ☐ Yes ☐ No If No, please explain: _____

_____

Additional information (if needed): _____

_____

Have you ever had a serious accident/illness or hospitalization? ☐ Yes ☐ No

Please list all past hospitalizations, surgeries, accidents, or illnesses in the chart below.

Reason for Previous Hospitalizations, Accident, Illness	**Date/Location of Hospitalization**

Have you had the following screenings (please check all that apply)?

☐ Hearing Screening Date: _____ Outcome: _____

☐ Vision Screening Date: _____ Outcome: _____

☐ Speech/Language Screening Date: _____ Outcome: _____

Primary Care Doctor: _____ Facility: _____ Phone Number: _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Are you currently being seen by a counselor/therapist? ☐ Yes ☐ No

If yes, name of current counselor/therapist _____ Length of Treatment _____

Are you currently being seen by a psychiatrist? ☐ Yes ☐ No

If yes, name of current psychiatrist _____ Length of Treatment _____

Have you ever been diagnosed with a mental health, emotional or psychological condition? ☐ Yes ☐ No

If yes, what diagnosis were you given? _____

When? _____

By Whom? _____

Have you ever received counseling services or been hospitalized for mental health or drug and alcohol concerns in the past? ☐ Yes ☐ No

If yes, please list previous counseling/hospitalizations for mental health/drug and alcohol concerns below

Date of service	Place/Provider	Reason for treatment	Were the services helpful

Additional information: _____

_____

SAFETY CONCERNS:

Are you presently suicidal? ☐ Yes ☐ No If Yes, please explain _____

Have you ever attempted to commit suicide? ☐ Yes ☐ No If yes, when and how? _____

_____

Is there a history of suicide in your immediate and/or extended family? ☐ Yes ☐ No

If Yes, please explain _____

_____

Have you ever inflicted burns or wounds on yourself? ☐ Yes ☐ No

Are you presently homicidal? ☐ Yes ☐ No If yes, please explain _____

_____

Additional Information: (please list additional information as needed to address past and current safety issues)

_____

_____

_____

CURRENT FUNCTIONING:

Do you have concerns about yourself in the following areas? (check all that apply)?

☐ Eating ☐ Hygiene/grooming ☐ Sleeping ☐ Activities/play ☐ Social Relationships

If so, please describe: _____

_____

Please rate your personality/temperament (how you behave the majority of the time in each of the following areas on a scale from 1 to 7 by placing a check above the number that best describes yourself):

ENERGY/ACTIVITY LEVEL (how active am I?)

CAN sit still and listen for long periods of time ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7

CAN'T sit still and listen for long periods of time

NEED FOR PHYSICAL ROUTINE (how much routine do I need)?

ENJOYS ROUTINE; easily upset when day doesn't go as usual _____: _____: _____: _____: _____: _____: _____
1 2 3 4 5 6 7

ENJOYS DOING THINGS DIFFERENTLY; may not notice small changes in

MOOD (what is my mood most of the time)?

ANXIOUS-usually frustrated and worried _____: _____: _____: _____: _____: _____: _____:
1 2 3 4 5 6 7

CALM-usually relaxed

HAPPY-usually enjoys what he/she is doing ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7

SAD-usually unhappy; hard time having fun

CURIOUS-usually eager to know something ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7

TIMID-usually not interested

ANGRY-easily frustrated and annoyed with others ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7

CALM usually peaceful with others

INTENSITY (how strongly do I express feelings, wants and opinions?)

MILD REACTION-calm and cooperative; Easily pushed around by others ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7

STRONG REACTION- may cry or yell over small things

PERSISTENCE (Can I stick with and complete tasks?)

Will stick with something until it is done ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7

Gives up on tasks; has trouble finishing things

SENSITIVITY TO SENSES (How sensitive am I to light, smells, sounds, and touching?)

Learns by seeing touching and using all senses ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7

Has strong reaction to noise, lights, hugging his/her or touching

PERCEPTIVENESS (How aware am I of feelings and emotions?)

Sympathetic to others; use words to tell how he/she feels ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Unaware of the feelings of others

ADAPTABILITY (How easily do I accept changes?)

Often fearful with new people and new situations ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 **Will easily meet** and accept new people and activities

ATTENTION SPAN/DISCTRACTIBILITY (How well do I pay attention?)

Stays focused on tasks until completed ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 **Easily sidetracked**; difficulty following directions

PARENT/CHILD RELATIONSHIP

Describe your parent's type of parenting (e.g. challenging, easy): _____

What did your parents find most challenging in you? _____

What kind of discipline worked best with you as a child? _____

EDUCATION

What is your highest level of Education? _____

Are you currently enrolled in school? ☐ Yes ☐ No Name of School _____

What grade are currently in (if summer, was grade is your child going into)? _____

How would you describe your attendance (currently)? (circle ALL that apply)

☐ Attending regularly ☐ Home-schooled ☐ Some truancy ☐ Alternative school ☐ Suspended

☐ Expelled ☐ Dropped Out ☐ GED program

How would you describe your achievement/grades in school? _____

How would you describe your attitude towards school/education? _____

Disciplinary or behavioral issues at school? ☐ Yes ☐ No If yes, describe: _____

_____

_____

Please check if you have had any of the following?

☐ Special Education Accommodations or a 504? Please describe: _____

☐ An Individualized Education Plan (IEP)? Please describe: _____

☐ Diagnosed Learning Disability? Please describe: _____

☐ Receiving special services at school? Please describe: _____

EMPLOYMENT:

Are you currently employed? ☐ Yes ☐ No

If employed, where are you working? _____ How long? _____

Do you enjoy your current job? ☐ Yes ☐ No

HOUSING:

Would you consider your housing to be: ☐ stable ☐ unstable If unstable, please describe: _____

_____

Please choose the one that best describes the current housing arrangement:

☐ Homeless ☐ Transitional Housing ☐ Emergency Shelter

How long have you lived in the current living situation? _____

How many times have you moved in the past two years? _____

What else do you think is important for us to understand about your housing/living situation?

_____

FOSTER CARE INVOLVEMENT:

Have you ever been in foster care? ☐ Yes ☐ No ☐ Unknown

From _____ age to _____ age Reason: _____

Type of Placement: ☐ Familial Placement ☐ Non-Familial Placement

Reason for leaving: ☐ Adopted ☐ Returned to Home ☐ Emancipated
☐ Ran away from care ☐ Other: _____

FAMILY MENTAL HEALTH HISTORY

Please identify if any members of your family have had a history of any of the following mental health/drug abuse/legal concerns.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Biological Child										

Additional Information: _____

_____

_____

ALCOHOL/DRUG ASSESSMENT:

Have you use tobacco or smokeless tobacco? ☐ Yes ☐ No ☐ Do not know

Do you use alcohol or drugs? ☐ Yes ☐ No ☐ Do not know

To your knowledge, have you used medications (prescriptions drugs or over the counter medication) recreationally? ☐ Yes ☐ No ☐ Do not know

To your knowledge, have you ever overdosed or passed out on alcohol or other drugs?

☐ Yes ☐ No If yes, when was the last overdose? _____

Have you ever experienced problems related to your alcohol use? ☐ Yes ☐ No

If yes, please check area and describe problems:

☐ Legal ☐ Social/Peer ☐ Work ☐ Family ☐ Friends ☐ Financial

Please describe: _____

If yes, have you continued to drink/use drugs? ☐ Yes ☐ No

LEGAL INVOLVEMENT:

Is there a current custody case involving your child? ☐ Yes ☐ No If yes, please describe below.

History of CPS involvement: ☐ None ☐ Past ☐ Current Please describe below.

Please indicate by checking your child's legal status below.

☐ No Involvement ☐ No Involvement ☐ Probation | Length: _____ ☐ Parole | Length: _____

☐ Charges Pending ☐ Prior Incarceration ☐ Lawsuit or other Court Proceeding

Charges: _____ Probation/Parole Officer's Name: _____

Contact #:_____

Additional Information: _____

_____

_____

_____

HISTORY OF ABUSE/NEGLECT:

Have you ever been abused or assaulted? ☐ Yes ☐ No If Yes, please complete the chart below.

Type of Abuse	By Whom? (relation to if any)	At What Age?	Was it reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No
☐ Abandoned/Neglected			☐ Yes ☐ No

Have you ever been a victim of bullying? ☐ Yes ☐ No

Do you worry about your safety now? ☐ Yes ☐ No

What else do you feel is important for us to know? _____

If applicable Has your child ever been abused or assaulted? ☐ Yes ☐ No ☐ Not Applicable

If Yes, please complete the chart below.

Type of Abuse	By Whom? (relation to if any)	At What Age?	Was it reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No
☐ Abandoned/Neglected			☐ Yes ☐ No

Has your child ever been a victim of bullying? ☐ Yes ☐ No

Do you worry about your child's safety now? ☐ Yes ☐ No

What else do you feel is important for us to know? _____

_____

HISTORY OF VIOLENCE:

Have you ever been accused of abusing or assaulting someone? ☐ Yes ☐ No If yes, please complete chart below.

Type of Abuse	To Whom?	Age of your child?	Was it Reported?
☐Sexual			☐ Yes ☐ No
☐Physical			☐ Yes ☐ No
☐Emotional			☐ Yes ☐ No
☐ Verbal			☐Yes ☐ No
☐Abandoned/Neglected			☐ Yes ☐No

Have you ever been known to bully other individuals ? ☐ Yes ☐ No

What else do you feel/believe is important for us to know? _____

_____

STRENGTHS/RESOURCES/SUPPORTS:

What limitations do you / family have (if any)? _____

What strengths does you /family have? _____

What resources do you have to help with your current problem? _____

_____

What experiences (past & present) will help you in improving the current situation? _____

_____

_____

What are you (and your family) already doing to improve the current situation? _____

_____

Who does/can you count on for support? ☐ Parents ☐ Boyfriend/Girlfriend ☐Siblings
☐ Extended Family ☐ Friends ☐ Neighbors ☐ School Staff ☐Church ☐ Pastor

☐ Group ☐Community Services ☐ Doctor ☐ Other: _____

CURRENT NEEDS/GOALS

What do you feel is your biggest need right now? _____
What do you most hope to gain from coming to counseling? _____
If you were to pick three goals to work on, what would they be?

Goal 1: _____
Goal 2: _____
Goal 3: _____

What else would you like for us to be aware of?

_____

_____

_____