ADULT CLINICAL INTAKE FORM

Name:_______________________________________ Today's Date:_______________

DOB:______________ Race:_______________ Preferred Pronoun: __________

What would you like therapy to help you change? ____
____

REFERRAL SOURCE:____
In an effort to coordinate care, we would like to obtain information from previous providers and/or your referral source. With your written authorization, we will be informing your physician (by letter) of your diagnosis and care here, communicating (as necessary) with your referring agent and requesting past mental health records.
Please check: **YES** and provide us with the names and addresses needed to prepare the authorization form(s) or check **No** if not necessary at this time.

Primary Care: ____ **Yes ____ No____**

Referral Source: ____ **Yes ____ No____**

Past Mental Health: ____ **Yes____ No____**

Family History

Were you raised by both biological parents? Y N If no, by whom?___________
Were your biological/adoptive parents divorced/separated? Y N If yes, how old were you?____
What # child were you in your family of origin?______ Of how many children?______
Were you raised with half siblings or step siblings? Y N

Did you **OBSERVE ABUSE** of any family member in your **FAMILY OF ORIGIN**? Y N DK
Were YOU **ABUSED/NEGLECTED** in your family of origin? Y N DK
Have your father, mother or siblings experienced any of the following problems?

Alcohol or drug abuse ? Y N DK If yes, whom?____________________________
Significant depression? Y N DK If yes, whom?____________________________
Suicidal attempts? Y N DK If yes, whom?____________________________
Significant anxiety? Y N DK If yes, whom?____________________________
Mental illness? Y N DK If yes, whom?____________________________
Hospitalization for emotional problems? Y N DK If yes, whom____________________________
Chronic physical illness? Y N DK If yes, whom?____________________________
Incarceration (jail/prison)? Y N DK If yes, whom?____________________________
Anger problems? Y N DK If yes, whom?____________________________

Have you experienced the loss by death of a:

Parent? Y N If yes, whom?______________________ Date:___________
Other family member? Y N If yes, whom?______________________ Date:___________
Close friend? Y N If yes, whom?______________________ Date:___________

OUTSIDE OF YOUR FAMILY OF ORIGIN, have you experienced abuse? Y N DK
Circle type of abuse: Sexual abuse Physical abuse Emotional abuse/harassment

Primary Relationships (Current or Past)

Currently married Y N How long?_________ Living with spouse Y N
In committed relationship Y N How long?_________ Living with partner Y N
Have you been divorced? Y N When?_____________
Have you been widowed? Y N When?_____________
Have you ended committed relationship? Y N When?______________
Name of spouse/significant other:____

Children (Include stepchildren)

First Name	Age	Year in School/Occupation	Living with you now?
			Y N
			Y N
			Y N
			Y N

Education

Graduated High School? Y N Higher Degrees?________________
Do you now have or have you had a learning disability? Y N DK

Employment

Are you presently employed? Y N Occupation/Job Title:_______________________
Are you satisfied with your present job? Y N
Do you think your employer is satisfied with your current performance? Y N

Religion

Do you have a religious preference? Y N If yes, describe:______________________
Are your spiritual beliefs an important part of your life? Y N DK

Legal

Have you ever been arrested/incarcerated? Y N When?_______ # of arrests? ________
Probation/Parole? Y N Probation Officer name/Phone number? _____________________

Stressors

Are you experiencing ***significant changes, loss or difficulties*** in the following areas?

Financial	Y N DK
Primary relationship (family/friends)	Y N DK
Housing	Y N DK
Physical health of self or family member	Y N DK
Access to health care	Y N DK
Occupation/employment	Y N DK
Legal	Y N DK
Education	Y N DK

Other____

Current Use of Alcohol/Drugs

Do you use alcohol? Y N
How many days per week? _______ How many drinks per day? ______

Do you use any of the following?
Cannabis/Marijuana ____
Cocaine ____
Methamphetamines ____
Opiods/Heroine ____
Other_____________
How many days per week? ______ How much each day? ______

In the last year have you experienced any of the following:

Picked up or charged with a drug-related driving offense?	Y N DK
Lost time from school or work because of use?	Y N DK
Experienced a medical problem because of use?	Y N DK
Been fired from a job because of use and its effects?	Y N DK
Felt you ought to cut down on your drinking or drug use?	Y N DK
Had people annoy you by criticizing your drinking or drug use?	Y N DK
Felt bad or guilty about your drinking or drug use?	Y N DK
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?	Y N DK

Do you use nicotine? Y N
How many days per week? _____ How much each day? ____

Do you drink caffeine? Y N
How many days per week? _____ How much each day? _____

Current Medical Care

Physician ____
Medical Diagnosis ____
____
Medications/Dosage ____
What type of exercise do you get?_____________________________Frequency________

Past Mental Health or Chemical Dependency Treatment
(Include outpatient treatment and hospitalizations):

Dates (Month/Year) Where Primary Therapist
____
____
____

If you scored any of the symptoms on the previous checklist, circle the difficulty level these problems have created for:

Work

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

Taking care of things at home

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

Getting along with others

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult