Psychotherapeutic Resources
YOUR CARING RESOURCE

ADULT CLINICAL INTAKE FORM

Name:_____ Date:_____

DOB:_____ Age: _____ Preferred Name:_____ Preferred Pronoun(s):_____

Ethnic Origin: _____ Sexual Orientation: _____ Gender/Gender Identity:_____

Current City: _____

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

Family of origin information: Please list the member(s) in your family with whom you grew up. (To include parents, adoptive parents, step-parents, siblings, adopted siblings, and step-siblings).

Name	Relationship to You	Current Age or Year of Death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional member(s) here: _____

_____

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 ORGIN**? Y N DK

Were you **ABUSED/NEGLECTED** in your fmily 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 DK If yes, whom? _____	Date: _____
Other family member?	Y N DK If yes, whom? _____	Date: _____
Close friend?	Y N DK 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:_____

Household Member(s) and Children (include stepchildren)

Name	Age	Relationship	Child lives with me	If "no" who does child live with and where?
_____			Y N NA	_____
_____			Y N NA	_____
_____			Y N NA	_____
_____			Y N NA	_____
_____			Y N NA	_____
_____			Y N NA	_____
_____			Y N NA	_____

Education:

Graduated High School?	Y N	Higher Degrees?_____
Are you currently enrolled in school?	Y N	If yes, what kind? _____
Do you now have or have you had a learning disability?	Y N DK	If yes, what kind? _____

Employment

Are you presently employed? Y N If yes, who is your employer? _____

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

Hobbies

Please list any hobbies you enjoy: _____

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

Military Service

Have you served in the military? Y N If yes, when? _____
What branch of service? _____

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? _____

Have you experienced any of the following:

	In the last year	**In your lifetime**
Picked up or charged with a drug-related driving offense?	Y N DK	Y N DK
Lost time from school or work because of use?	Y N DK	Y N DK
Experienced a medical problem because of use?	Y N DK	Y N DK
Been fired from a job because of use and its effects?	Y N DK	Y N DK
Felt you ought to cut down on your drinking or drug use?	Y N DK	Y N DK
Had people annoy you by criticizing your drinking or drug use?	Y N DK	Y N DK
Felt bad or guilty about your drinking or drug use?	Y N DK	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	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? _____

Past Use of Alcohol/Drugs

Has alcohol or drugs caused any problems for you in the past? Y N

If yes, what kind of problems? _____

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

Anything else you would like to add: _____
_____
_____
_____
_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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