Adult Intake

Name_____ Date_____

Birthdate_____ Age_____

Telephone_____ _____

(home/cell) (work)

Okay to call you at home? Yes No Okay to leave messages at home? Yes No
Okay to call you at work? Yes No Okay to leave messages at work? Yes No

Address_____

_____

City State Zip County

EMAIL ADDRESS:_____

Okay to send email regarding scheduling? Yes No

Okay to send email regarding billing? Yes No

General Questions:

Please list 10 words that describe you well:

_____

_____

_____

Describe a dream you would seek after if you knew nothing could interfere with your achieving it:

_____

_____

_____

_____

_____

What personal strengths have helped you in the past deal with difficulties similar to those of concern today?

_____

_____

_____

_____

Where do you turn for support? Family, friends, work relationships? Faith?

_____
_____
_____

What are your current interests or hobbies?

_____
_____
_____
_____

What are your current life pursuits? (employment, education, volunteer work, etc.)

_____
_____
_____
_____

What has brought you in for therapy?

_____
_____
_____
_____

If therapy can do for you all that you are hoping, what will you have when you are finished that you do not have now?

_____
_____
_____
_____

Medical/ Mental Health History

General Health Questions

Do you get regular exercise? If so, what forms of exercise do you enjoy?

_____

_____

Please describe your feelings about your current eating habits:

_____

_____

Do you smoke, drink, or use other chemical substances? If so, with what frequency?

_____

_____

*What was the approximate date of your last physical exam?*_____

Physical Symptoms (experienced in past 6 months):

____shortness of breath ____poor memory ____fatigue
____overweight ____poor appetite ____underweight
____back pains ____chest pains ____can't sleep
____always hungry

____panic attacks
____other (specify)_____

Do you have allergies?_____ If so, describe types:_____

Do you have asthma?____ Do you take maintenance medication for this?_____

Are you currently being treated for any other medical problems? If so, please list:

_____

_____

_____

Physician Name:_____Prescription(s): _____

_____

_____

Physician Name:_____Prescription(s): _____

_____

_____

Other mental health or chemical dependency treatments sought (both past and present):

Location:_____
Therapist:_____
Psychiatrist:_____
Prescription(s):_____
Date(s) of Service:_____

Please briefly describe the therapy and your overall feelings about the experience:

_____
_____
_____

Location:_____
Therapist:_____
Psychiatrist:_____ Prescription(s):_____
Date(s) of Service:_____

Please briefly describe the therapy and your overall feelings about the experience:
_____
_____
_____

**Please list others on back.*

Stressors

Please circle any of the following stressors that either you or a family have encountered, as well as the approximate date(s) surrounding their occurrence.

Stressor:	Date(s):
Unemployment of a parent	
Divorce of parent(s)	
Death of a loved one	
Serious Illness	
Physical Abuse	
Sexual Abuse	
Emotional/Verbal Abuse	
Eviction/foreclosure from home	
Legal problem	
A move or change of households	
Others (specify below: _____ _____ _____	

Childhood/Family

Development:

Your approximate due date:_____ Birth date:_____

Do you know your birth and delivery story? (On time? Difficult birth? Complications? Post-partum depression in Mother? Other?)

_____

_____

_____

_____

Were you breast fed or bottle fed?_____ until what age?_____

Were there any concerns with your developmental progress? If so, describe the areas of concern:

_____

_____

_____

_____

Who cared for you as a child?_____

_____

Where was your first home?_____

Other childhood experiences you would like to share:_____

_____

_____

Academic/ Work:

How was your early school experience? Academically? Socially?

_____

_____

Did you have childhood recreational interests that helped shape your life and character?

_____

_____

What role has education played in your adult life?

_____

_____

_____

Early Family Life

Please list the name, ages, and 3 characteristics of each member of your childhood family (include pets or friends, if appropriate):

_____

_____

_____

_____

_____

_____

_____

Please describe briefly how your caregivers' extended family dynamics influenced your childhood:

_____

_____

_____

_____

_____

_____

Who were the most supportive, influential people in your life as a child?

_____

_____

_____

_____

_____

If you could go back and change anything in your childhood, what would it be?

_____

_____

_____

_____

_____

_____

If you could carry forward certain aspects of your childhood into your adult life, what would they be?

_____

_____

_____

_____

_____

Please note any specific health conditions that have impacted your family members (parents, siblings, grandparents, aunts or uncles): (e.g. heart conditions, diabetes, thyroid, chemical dependency, depression)

_____

_____

_____

_____

_____

_____

Current Family

(For some, family may be a group of close friends with whom they live, for others it may be living with a spouse and their children; please answer these questions according to your definition of family).

Who are the members of your current family/household? Please list names and ages (including pets):

_____

_____

_____

Please list some family strengths:

_____

_____

_____

Please describe challenges in your family experience (past or present):

_____

_____

_____

What ways do you share time with family?_____

_____

_____

Other information you believe will be important to your therapy:

_____

_____

_____

_____

ISSUES INVENTORY **Name_____Date_____**

Below you will find a list of problems people frequently need help with.
Look down the list and rate yourself as to the degree of severity that each subject presents.
Check the numbers from 1 (no problem) to 5 (severe problem) that apply.

Subject	No Problem 1	2	3	4	Severe 5
Crying for no Reason					
Can't enjoy myself					
Feeling lonely					
Feeling down/ depressed					
Feeling hopeless					
Low self-esteem/ self-confidence					
Feeling unhappy about myself					
Difficulty expressing feelings					
Dealing with traumatic experiences					
Feeling anxious					
Feeling angry					
Feeling out of control					
Absentmindedness					
Can't make decisions					
Intrusive thoughts					
Difficulty concentrating					
Racing Thoughts					
Thinking about suicide					
Thinking about hurting someone else					
Trouble controlling aggression					
Impulsivity or recklessness					
Thoughts that confuse or scare me					
Difficulty being assertive					
Concerns re. use of pornography					
Balancing responsibilities					
Procrastination/ Lack of motivation					
Problems with grades/ school work					
Time management					
Easily distracted					
Disorganization					
Test anxiety					
Anxiety regarding public speaking					
Perfectionism					
Worried about future career					

Feeling rejected by others					
Trouble making or keeping friends					
Difficulty with authority					
Sexual issues					
Racial/ethnic/cultural issues					
Relationships with females					
Relationships with males					
Relationship with roommate/friend					
Relationship with family					
Relationship with romantic partner					
Relationship with my children					
Premarital					
Substance use of family member					
Substance use of friend					
Own use of alcohol/drugs					
Difficulty with sleep (sleeping too much; difficulty falling asleep or staying asleep)					
Problems with eating					
Struggles with body image					

Please indicate below those parts of your life that give you pain or that you struggle with. Then show the desired change in yourself or your behavior that you wish to accomplish through therapy. Problems and struggles may involve internal factors such as thoughts, values, feelings, intentions, etc. Or the issues may involve external factors such as your relationships with others, school, jobs, etc.

Problem	Desired Change

After making your list above, please go back and number the problems in order of importance to you (with "1" being most important).