

Adult Intake, 2024

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:

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.

Check the numbers 1 (no problem) to 5 (severe problem) as they relate to your experience.

Subject	No Problem					Severe
	1	2	3	4	5	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/ schoolwork					
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 describe the problems or sources of pain you hope to address, and the change you desire. After making your list, please go back and number the problems in order of importance to you, with '1' being the most important.

Problem	Desired Change