Intake Information: Adult

Today's date: _____

Name _____ DOB _____ Gender_____ Age_____ Race/Ethnicity_____

Address_____City_____State_____Zip_____

Telephone cell _____ home_____

Email: _____ How did you hear about me?_____

Emergency Contact _____ Relationship _____ Phone _____

Marital Status ☐ single ☐ married ☐ partnered ☐ divorced ☐ separated other:_____

Occupation _____ Employer_____ Years of Education_____

Sexual ID: Heterosexual ☐ Bisexual ☐ Lesbian ☐ Gay Male ☐ Transgender ☐ Comment_____

Names of Significant Relationships – Partner/s, Parents, Siblings, Other Important People in your life:

Name	Example: Mary Ann	Age	26	Relationship	Sister, don't get along, lives in Texas, married, 1 son
Name		Age		Relationship	
Name		Age		Relationship	
Name		Age		Relationship	
Name		Age		Relationship	
Name		Age		Relationship	
Name		Age		Relationship	
Name		Age		Relationship	

Describe the problem that brought you here in your own words:

Please check all of the behaviors and symptoms that you currently consider problematic:

☐ Distractibility	☐ Change in appetite	☐ Suspicion/paranoia
☐ Hyperactivity	☐ Lack of motivation	☐ Racing thoughts
☐ Impulsivity	☐ Chronic pain	☐ Over spending
☐ Problems focusing	☐ Withdrawal from people	☐ Excessive energy
☐ Boredom	☐ Anxiety/worry	☐ Wide mood swings
☐ Poor memory/confusion	☐ Panic attacks	☐ Sleep problems
☐ Seasonal mood changes	☐ Fear away from home	☐ Nightmares
☐ Sadness/depression	☐ Social discomfort	☐ Eating problems
☐ Loss of pleasure/interest	☐ Obsessive thoughts	☐ Gambling problems
☐ Hopelessness	☐ Compulsive behavior	☐ Computer addiction
☐ Thoughts of death	☐ Problems with pornography	☐ Aggression/fights
☐ Self-harm behaviors	☐ Frequent arguments	☐ Parenting problems
☐ Crying spells	☐ Irritability/anger	☐ Sexual problems
☐ Loneliness	☐ Thoughts of hurting others	☐ Relationship problems
☐ Low self-worth	☐ Flashbacks	☐ Work/school problems
☐ Guilt/shame	☐ Hearing voices	☐ Alcohol/drug use
☐ Fatigue	☐ Seeing things	☐ Phobias
☐ Anorexia	☐ Shortness of breath	☐
☐ Bulimia	☐ Sweating	☐
☐ Weight changes	☐ Heart racing	☐

☐ Other _____

_____

_____

_____

Are your problems affecting any of the following?

☐ Handling everyday tasks	☐ Self-esteem	☐ Relationships	☐ Hygiene
☐ Work/School Housing	☐ Legal matters	☐ Finances	☐ Health
☐ Recreational activities	☐ Sexual activity	☐ Other _____	

History of Traumatic Life Events – accidents, witnessing trauma to others, natural disasters, serious illness, loss or injury to loved ones, death of loved one, assault ☐ Yes ☐ No _____

_____

History of Abuse physical_☐_, sexual_☐_, emotional_☐_ ? Comment _____

_____

Suicide Attempt or Thoughts? ☐ Yes ☐ No If Yes, when _____ where _____ **got help?** ☐ Yes ☐ No

_____

Alcohol # of days/wk _____ # of drinks/day _____ # of days/month you have more than 5 drinks _____ Previous Alcohol treatment? _____

How would you like to change your drinking? _____

Other Drugs including Marijuana # of days/wk _____ # of hits/day _____ # of days/month you have more than 5 hits _____ Previous Drug treatment? _____ How would you like to change your use of drugs? _____

Tobacco Smoker ? ☐ Yes ☐ No Cigarettes/day _____ started at age _____ # of times you've quit _____ Want to change? ☐ Yes ☐ No

History of past mental health problems/diagnosis or counseling? ☐ Yes ☐ No

Diagnosis	Dates treated or age	By whom	Comments
_____	_____	_____	_____
_____	_____	_____	_____

Experience with a Therapist? ☐ Yes ☐ No Helpful? ☐ Yes ☐ No Comment _____

Experience with a PMHNP? ☐ Yes ☐ No Helpful? ☐ Yes ☐ No Comment _____

Experience with a Psychiatrist? ☐ Yes ☐ No Helpful? ☐ Yes ☐ No Comment _____

Medications previously taken for mental health issues and no longer taking:

Name	Year/s Used	Dosage	Usefulness/Side Effects/Concerns?
			things that are problemsthings that are problemsthings that are problemsthings that are problemsthings that are problemsthings that are problems

Previous hospitalization for mental health problems? ☐ Yes ☐ No Please explain circumstance: _____

Name of Primary Care Provider: _____ Phone _____

Address_____ _____ Fax _____

Date of Last Physical Exam: _____ Purpose of Visit: _____

Ht _____, **Wt** _____ Weight range _____ to _____ Ideal Wt _____ BP _____ HR _____ (will check in office)

Allergies? ☐ Yes ☐ No If Yes, list and Reaction: _____

Pharmacy Name _____ Location _____ Phone _____

Current prescription medication/ Over the counter meds/ Herbal remedies / Nutritional Supplements:

Name	Dosage/Frequency	Purpose	Comment / Provider's Name

Women Only - Menstrual/Pregnancy History

Age with first period _____ cramps? ☐ Yes ☐ No heavy bleeding? ☐ Yes ☐ No PMS? ☐ Yes ☐ No medication? ☐ Yes ☐ No _____

Pregnancies? ☐ Yes ☐ No # of Term Babies? _____ Years born? _____ # Preterm Babies? _____ Years born? _____

# of Miscarriages? _____ # of Terminations? _____ Complications with pregnancies? _____

#Vaginal Births _____ #Cesarean Births _____ Started Menopause ? No ☐ Yes ☐

Current Birth Control Method _____ Problems with it? _____

Previous Birth Control Methods _____

Men Only

Age you went thru puberty – first ejaculation? _____ Age of voice change? _____ Age you reached your full height? _____

Women and Men Sexual History

Age of first sexual experience? _____ Age of first intercourse? _____ Able to orgasm now? _____ Problems with orgasm? _____

Do you have a current sexual partner? ☐ Yes ☐ No Is there anything you wish to discuss about your sexual relationship? ☐ Yes ☐ No

_____

How would you like to improve your sexual health? _____

What Sexually Transmitted Infections have you had? _____How Many Sexual Partners have you had in the past year? _____ Have you had unprotected sex ? _____ Have you ever been forced to have sex ? _____

Are you currently trying to conceive? ☐ Yes ☐ No Do you wish to have a child/ren in the future? ☐ Yes ☐ No

Please note presence of Family history of mental health problems:

Issue	Relationship to you	Age of Diagnosis?	Treatment?
☐ Depression			
☐ Anxiety			
☐ Schizophrenia			
☐ Bipolar (manic/depressive)			
☐ Post-traumatic stress disorder			
☐ Alcohol abuse			
☐ Other substance abuse			
☐ ADHD/ADD			
☐ Suicide/or attempted			
☐ Other			

Presence of personal or family medical problems (Check if Yes):

Problems	Personal History You used to have	You have Currently	Family History	Relationship to you? (mom, dad, MGM etc)	Comment
☐ Thyroid Disease					
☐ Anemia					
☐ Liver Disease					
☐ Kidney Disease					
☐ Heart Disease					

☐ ☐ ☐

Problems	Have now	Used to	Family	Relation to you	Comments
☐ Diabetes					
☐ Asthma					
☐ Stomach Intestinal					
☐ Cancer					
☐ Epilepsy					
☐ Pain					
☐ High Cholesterol					
☐ High Blood Pressure					
☐ Head trauma					
☐ Alcohol					
☐ Drugs					
☐ Cigarette					
☐ Caffeine					
☐ Other:					

Diet on a typical day_____

_____

How would you like to change your diet?_____

Exercise in a typical week_____

How would you like to change your exercise? _____

Sleep: Ave # of hrs/night _____ Go to bed @_____ Get up @_____ # of wakings _____ Sleep Goal _____

Sleep aides/meds _____

Nightmares ☐ Yes ☐ No Comment _____

All Electronics: Ave # of hours/day _____ Work _____ Home _____ Type (phone, computer, games, ipod etc) _____

_____

What apps and video games do you interact with on a regular basis?_____

How much of your connecting with people happens via digital devices? 0-20% _____ 20-40% _____ 40-60% _____ 60-80% _____ 80-100% _____

How would you like to change your use of electronics? _____

Friends: Ave # of hours/week _____ Things you do together _____

How would you like to change your relationship to friends?_____

Hobbies: _____

How would you like to change your relationship to hobbies? _____

Relationships: Current partner ☐ Yes ☐ No Name _____, year you met? _____, Long term Plans _____

Open Relationship ☐ Yes ☐ No, How would you like to change your relationship to your partner?_____

_____

Previous significant relationships – first name/year-s/how they ended _____

_____

_____

School: Name _____ Start Date _____ Satisfaction ***Hate It*** 0 1 2 3 4 5 6 7 8 9 10 ***Love It***

Previous Schools _____

_____

Work: Current Job/s _____ Start Date _____ Satisfaction ***Hate It*** 0 1 2 3 4 5 6 7 8 9 10 ***Love It***

Previous Jobs: _____

_____

Safety: Gun in your house? ☐ Yes ☐ No Wear a helmet when you bike? ☐ Yes ☐ No Motorcycle? ☐ Yes ☐ No Ski ☐ Yes ☐ No

Early Childhood: Vaginal _☐_ Cesarean Section _☐_ Breastfed _☐_ Bottlefed _☐_ Mom smoked ☐ Yes ☐ No _____

Colicy or Difficult ☐ Yes ☐ No Developmental Issues: Gross Motor ☐ Yes ☐ No Fine Motor ☐ Yes ☐ No Behavioral ☐ Yes ☐ No

Preschool Issues ? _____

Grade School Issues ? _____

Middle School Issues ? _____

High School Issues ? _____

College Issues? _____

More details about what brought you in to see me today:

_____

_____

_____

What are you most hoping to accomplish by coming to see me?

_____

_____

_____

Other Questions or Comments?

_____

_____

_____

_____

Client Signature _____ **Date** _____

FOR OFFICE USE ONLY

MSE: R apple, W dove, C Park; Ox4; $3.73; Pizza; Wallet; World; Parable; 3 Wishes; Future Job; memory