

ADULT INTAKE FORM

(Please complete in ink)

1. Full Name: _____Sex: _____DOB: _____

2. Contact Ph #: _____Email: _____

3. Mailing Address: _____

4. Emergency Contact Name and Telephone #: _____

5. Primary Care Physician: _____

6. Do you give permission for regular updates to your primary care physician? Yes___No_____

What is the problem(s) for which you are seeking help?

1. _____

2. _____

3. _____

Current Symptoms Checklist (check for any symptoms present):

( ) Racing thoughts ( ) Excessive worry ( ) Suspiciousness

( ) Impulsivity ( ) Anxiety attacks ( ) Excessive guilt

( ) Increased risky behavior ( ) Avoidance ( ) Increased irritability

( ) Increased libido ( ) Hallucinations ( ) Excessive energy ( ) Decreased need for sleep

List ALL current prescription medications and how often you take them (if none, write none).

Medication:	**Dose:**	**When Started:**

List any current over-the-counter medications/supplements/vitamins:

_____

_____

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect?

Yes ___No ___If yes, please describe when, where, and by whom: _____

_____

Have you been exposed to Domestic Violence? Yes ___No ___

Legal History

Have you ever been arrested? Yes ___No ___

Do you have any pending legal problems? If so, please briefly explain: _____

_____

Past Psychiatric History

Any outpatient treatment? Yes ___No ___If yes, please describe below:

Reason: Dates: Provider:

_____

_____

_____

Psychiatric Hospitalization

Any psychiatric hospitalizations? Yes ___No ___If yes, please describe below:

Reason: Date/Length of stay: Hospital:

_____

_____

_____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) No Schizophrenia ( ) Yes ( ) No

Depression ( ) Yes ( ) No Post-traumatic stress ( ) Yes ( ) No

Anxiety ( ) Yes ( ) No Alcohol abuse ( ) Yes ( ) No

Anger ( ) Yes ( ) No Violence ( ) Yes ( ) No

Other substance abuse ( ) Yes ( ) No Suicide ( ) Yes ( ) No

If yes, who had each problem? _____

_____

Past Psychiatric Medications

If you have ever taken any of the following medications, please state if they were helpful and any side-effects you remember (it is ok if you do not remember all aspects, please fill in what you can).

WHEN: **DOSE:** **RESPONSE/SIDE EFFECTS:**

Antidepressants:

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Other _____

Mood Stabilizers:

Tegretol (carbamazepine) _____

Lithium _____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Topamax (topiramate) _____

Other _____

Antipsychotics/Mood Stabilizers:

Abilify (aripiprazole) _____

Risperdal (risperidone) _____

Seroquel (quetiapine) _____

Zyprexa (olanzepine) _____

Geodon (ziprasidone) _____

Clozaril (clozapine) _____

Past Psychiatric Medications- continued

If you have ever taken any of the following medications, please state if they were helpful and any side-effects you remember (it is ok if you do not remember all aspects, please fill in what you can).

WHEN: **DOSE:** **RESPONSE/SIDE EFFECTS:**

Antipsychotics/Mood Stabilizers (cont.):

Haldol (haloperidol) _____

Prolixin (fluphenazine) _____

Other _____

Sleep Medications:

Ambien (zolpidem) _____

Sonata (zaleplon) _____

Rozerem (ramelteon) _____

Restoril (temazepam) _____

Desyrel (trazodone) _____

Other _____

ADHD Medications:

Adderall (amphetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Strattera (atomoxetine) _____

Other _____

Antianxiety medications:

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Other _____

Substance Use

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

Check if you have ever tried the following: If yes, how long and when did you last use?

Cocaine ( ) Yes ( ) No _____

Stimulants (pills) ( ) Yes ( ) No _____

Heroin ( ) Yes ( ) No _____

Methamphetamine ( ) Yes ( ) No _____

Marijuana ( ) Yes ( ) No _____

Pain killers (not prescribed) ( ) Yes ( ) No _____

Methadone ( ) Yes ( ) No _____

Sleeping pills ( ) Yes ( ) No _____

Alcohol ( ) Yes ( ) No _____

Ecstasy ( ) Yes ( ) No _____

Other ( ) Yes ( ) No _____

***How many caffeinated beverages do you drink a day?** Coffee _____Sodas _____Tea _____

Energy Drinks _____None _____

Do you currently smoke cigarettes? ( ) Yes ( ) No

How many packs currently per day on average? _____How many years? _____

Have you smoked in the past? ( ) Yes ( ) No

How many years did you smoke? _____When did you quit? _____

Do you currently smoke a pipe, cigars, or use chewing tobacco? ( ) Yes ( ) No

How often per day on average? ____How many years? _____

Have you used a pipe, cigars or chewing tobacco in the past? ( ) Yes ( ) No

How often per day on average? ____How many years? _____

Family Background and Childhood History

Where did you grow up? _____

List your siblings and their ages: _____

_____

Has anyone in your immediate family died? _____

Medical History

Current Weight: _____ Height: _____

Any allergies? _____

Current medical problems: _____

_____

Past medical problems (Including surgeries and prolonged hospital stays): _____

_____

_____

Your Exercise Level

Do you exercise regularly? ( ) Yes ( ) No How often? _____

FOR WOMEN ONLY: Date of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method: _____

How many times have you been pregnant? _____ How many live births? _____

Personal and Family Medical History

Check if yourself or anyone in your family has had any of the following:

Thyroid Disease Yourself ( ) Family( ) Anemia Yourself ( ) Family( )

Liver Disease Yourself ( ) Family( ) Chronic Fatigue Yourself ( ) Family( )

Kidney Disease Yourself ( ) Family( ) Diabetes Yourself ( ) Family( )

Asthma/respiratory problems Yourself ( ) Family( )

Stomach or intestinal problems Yourself ( ) Family( )

Cancer (type) _____Yourself ( ) Family( )

Personal and Family Medical History- continued

Check if yourself or anyone in your family has had any of the following:

Fibromyalgia Yourself ( ) Family( ) Heart Disease Yourself ( ) Family( )

Epilepsy or seizures Yourself ( ) Family( ) Chronic Pain Yourself ( ) Family( )

High Cholesterol Yourself ( ) Family( ) High blood pressure Yourself ( ) Family( )

Head trauma Yourself ( ) Family( ) Liver Problems Yourself ( ) Family( )

Other_____Yourself ( ) Family( )

Educational History

Highest Grade Completed? _____

Did you attend college? ( ) Yes ( ) No If yes, Where? _____Major? _____

Occupational History

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Have you ever served in the military? ( ) Yes ( ) No

Relationship History and Current Family

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? ____

If not married, are you currently in a relationship? ( ) Yes ( ) No; If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ( ) Yes ( ) No;. If so, how many?

Do you have children? ( ) Yes ( ) No; If yes, list ages and gender: _____

_____

List everyone who currently lives with you: _____

_____

Spiritual Life

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

_____

Does your involvement make things: ( ) more helpful ( ) more stressful

Please explain: _____

_____

_____

Other comments or concerns

_____

_____

_____

_____

Printed Name: _____

Signature: _____ **Date:** _____

For Office Use Only

Name of Person Receiving Forms: _____

Signature: _____ Date: _____