Adult Intake

Please Describe the reason for which you seek treatment:_____
_____
_____
_____
_____
_____
_____
_____

Are you having or have experienced any of the following problems:

_____ excessive crying _____feel sad _____ oversleeping _____ Insomnia

_____ little interest and pleasure in doing things _____ low self esteem

_____thoughts that you would be better off dead or of hurting yourself in some way

_____difficulty concentrating on things _____ over eating _____loss of appetite

_____ tired or little energy _____excessive fear or worry _____ panic attacks

_____ sexual problems _____angry outburts _____ irritability

_____being so restless that its hard to sit still _____ feel on edge _____ headaches

_____ excessive fear of gaining weight or concerned with diets _____ obsessive thoughts

_____ obsessive rituals _____binging or purging _____ gastrointestinal issues

_____abuse alcohol or drugs _____ gambling addiction _____ excessive exercise

_____ see or hear things that other people do not hear or see _____ no friends

_____ conflictual relationships with others _____ self destructive behavior

_____ impulsivity _____ engage in high risk behaviors _____ intrusive memories of past abuse

_____ unexplained periods of time in which you have high energy and feel a decreased need for sleep

_____ cutting or other self harming behaviors _____ fear of being in crowded places

_____ suicide attempt _____psychiatric hospitolization

What are your goals for treatment

_____
_____
_____

What strengths or support systems do you have that will assist you in meeting these goals:_____
_____

Do you have any medical conditions? If yes please list

_____
_____
_____

What is your physician's name and contact number :_____

Have you been in counseling before? _____ If so how long and when? (please list providers names and duration of treatment_____
_____
_____
_____
_____

Have you ever tried to commit suicide or harm yourself in any way? _____ If yes please explain_____
_____
_____

Did you find the counseling helpful? Please Explain

_____
_____
_____Have you ever taken any medications for mental health purposes? If so please list all medications, dosage, how long you took it, side effects experienced and effectiveness_____
_____
_____
_____
_____

Do you have any allergies to medication?

_____
_____

Are you currently taking any medication for medical reasons? If so please list_____
_____
_____

Does anyone in your family struggle with any mental health issues? _____ If yes please explain_____
_____
_____

Please list the names and ages of your family members

Mother_____ age_____

Father _____ age _____

Sibling _____ age Sibling _____ age_____

Sibling _____ age _____ Sibling _____ age _____

Sibling _____ age _____ Sibling _____ age _____

Spouse/partner _____ age _____ Child _____ age _____

Child_____ age_____ Child _____ age _____

Child _____ age _____ Child _____ age_____

Please describe your *parent*'s parenting style and the dynamics of your family of origin_____
_____
_____
_____
_____

Describe *your* parenting style (if applicable)_____
_____
_____
_____

Do you have any parenting concerns ?_____ If yes please explain
_____
_____
_____
_____

If you are a Perinatal or Postpartum client please see attached assessment

Please list all recreational drugs that you have used and include frequency and duration of use:

_____
_____
_____
_____
_____
_____

How often do you drink alcohol?_____ How much do you drink?
_____

Have you ever been in trouble with the law as a direct result of your alcohol consumption? _____ If yes please
explain_____
_____
_____

Has anyone said to you that you should cut down on your drinking?_____ Has drinking impacted your finances or health in any way?_____

Do you believe that you are getting enough rest?_____

What time do you go to bed and what time do you wake up?_____

Do you smoke cigarettes?_____ If so how often_____

Do you drink caffeine?_____ If yes how often _____

What is your diet like?_____

What time of the day do you notice you tend to feel fatigued?
_____

Do you use any natural herbs or supplements? If so describe
_____
_____
_____

Do you do any form of exercise? _____ if Yes how
often_____

Is spirituality or religion important to you? _____ If so please describe your spiritual and/or religious beliefs and how you would like to incorporate these beliefs in your treatment_____
_____
_____
_____
_____

Are there any cultural beliefs ,rituals or traditions which you believe I should know about and could be important to your treatment plan? Please
explain_____
_____
_____

_____
_____

Have you ever been a victim of domestic violence/physical abuse? _____ If Yes please explain_____
_____
_____
_____

Was it ever reported?_____

Have you ever been a victim of sexual abuse or rape? _____ If yes please explain_____
_____
_____
_____

Was it ever reported?_____

Have you ever hit anyone?_____ Please explain_____
_____
_____

Have you ever been incarcerated?_____ If so for what crime and how long?
_____
_____
___

How would you describe your relationship with your spouse or partner (if applicable)_____
_____
_____. Are there any aspects of your relationship that you would want to improve? Please describe_____
_____
_____
_____
_____

Are you experiencing any school or work stress?_____ If yes explain
_____
_____
_____

Please list your highest level of education/training
_____
____

What are your hobbies or pleasurable activities?
_____

_____
_____
____

If you had more time or less stress in your life what kinds of activities do you wish you could do more of?

_____
_____
_____
_____

Is there any other important information that has not been asked in this questionnaire that you believe is important for me to know about you?

_____
_____
_____
_____
_____