ADULT INTAKE

CLIENT INFORMATION

Today's Date ___/___/___ Referred by: _____ Client's Name: _____

Date of Birth: ___/___/___ Age: _____

Client's Address: _____ City: _____ State:____ Zip:_____

Phone (Home): _____ (work): _____ (cell): _____ (other): _____

E-mail: _____ Occupation: _____ Employer: _____

Marital Status: ☐Married ☐Engaged ☐Widowed ☐Divorced ☐Separated ☐Live with partner ☐Other: _____

Name of Spouse: _____ Do you attend church? ☐Yes ☐No Church Name: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relation: _____

MENTAL HEALTH TREATMENT

Have you ever seen a therapist before? ☐Yes ☐No Therapist/Counselors Name: _____

Have you seen a Psychiatrist or Psychiatric Nurse Practitioner? ☐Yes ☐No Psychiatrist / PNP Name: _____

Have you ever had a mental health diagnosis? ☐Yes ☐No If yes: _____

MEDICAL AND PERSONAL

Primary Care Physician: _____ Office phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Specialist: _____ Type of Physician: _____ Office phone: _____

Address: _____ City: _____ State: _____ Zip: _____

FAMILY COMPOSITION

Who currently reside in the same house as the client? Please include family members as well.

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

ADULT INTAKE

CURRENT MEDICATIONS

Name of Medication	Dosage	Frequency	Treatment for

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- ☐ Depressed
- ☐ Restlessness
- ☐ Overeating
- ☐ Withholding food
- ☐ Confusion
- ☐ Nausea
- ☐ Hallucinations
- ☐ Upset bowels
- ☐ Heart Racing
- ☐ Lack of energy
- ☐ Racing thoughts
- ☐ Stomach Aches
- ☐ Indecisiveness
- ☐ Dizziness
- ☐ Self-mutilation
- ☐ Poor memory
- ☐ Chest pains
- ☐ Violent behaviors
- ☐ Guilty conscience
- ☐ Seizures or convulsions
- ☐ Anxiety or nervousness
- ☐ Feelings of unreality
- ☐ Parent / Child conflicts
- ☐ Heart Irregularities
- ☐ Feelings of sadness
- ☐ Addicted to Pornography
- ☐ Feelings of worthlessness
- ☐ Suicidal Thoughts
- ☐ Always "on guard"
- ☐ Excessive shame or guilt
- ☐ Unusual sexual behavior
- ☐ Feelings of Loneliness
- ☐ Headaches
- ☐ Periods of "going blank"
- ☐ Sleeping too much
- ☐ Outbursts of anger
- ☐ Inability to sleep
- ☐ Shortness of breath
- ☐ Financial difficulties
- ☐ Difficulty making choices
- ☐ Uncontrolled crying spells
- ☐ Loss of Consciousness
- ☐ Weight loss/gain
- ☐ Involuntary body trembling
- ☐ Low or decreased sex drive
- ☐ Feelings of emptiness / numbness
- ☐ Tingling or numbness
- ☐ Excessive Sweating
- ☐ Sensitivity to criticism
- ☐ Fear of "going insane"
- ☐ Fear of being alone
- ☐ Recurrent thoughts or worries
- ☐ Feeling compelled to do things
- ☐ Trouble getting along with others
- ☐ Avoiding people / Social Situations
- ☐ Neglected hygiene / appearance
- ☐ Weight loss by vomiting / laxatives
- ☐ Loss of interest in usual activities
- ☐ Difficulty thinking / distractions
- ☐ Preoccupations w/bodily functions
- ☐ Difficulties at work or school
- ☐ Constant focus on religious thoughts
- ☐ Moodiness / changeable moods
- ☐ Feeling as if reliving past trauma
- ☐ Excessive fear of persons / places
- ☐ Feelings of doom or death
- ☐ Recurring distressing dreams
- ☐ Intimate Partner conflicts

PRESENTING PROBLEM

Please describe what brings you in here today?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____