

Adult Psychotherapy Intake Form

Full Name _____ Today's Date _____

Male _____ Female _____ Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Is it OK to contact you at home? _____ OK to leave a message? _____

Mobile Telephone _____ Is it OK to contact this number? _____ OK to leave a message? _____

How did you learn about the psychotherapy services provided at this office: _____

REASON FOR SEEKING TREATMENT:

Please briefly describe the problems you are experiencing.

What has happened to cause you to seek help now?

What do you hope to be able to do or achieve as a result of treatment?

How do you handle stressors and/or cope with the problems you have described:

Do you currently have thoughts of harming yourself? yes no

Have you in the past? yes no If Yes, how long ago? _____

Do you currently have thoughts of wishing you were dead? yes no

Do you currently have urges to hurt, harm, or kill someone else? yes no If yes, whom? _____

Have you **ever** seriously considered suicide or felt like harming someone else? yes no

If yes, please explain: _____

Name of Current Psychiatrist (and phone #): _____

Have you ever had previous therapy/counseling of any kind? yes no If yes, when, with whom, and for how long?

Have you ever been hospitalized for emotional problems? yes no Or for substance abuse problems? yes no

If yes to either of the above, please note when, where, and for how long were you hospitalized? _____

Please check all of the items below that describe your situation:

- Abuse/trauma – physical, sexual, emotional, neglect
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues
- Codependence
- Confusion
- Compulsions and/or obsessions (thoughts or actions that repeat themselves)
- Decision-making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation, marital conflict, infidelity/affairs
- Drug use – prescription medications, over-the-counter medications, street drugs
- Eating problems – overeating, undereating, appetite, vomiting
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Inferiority feelings
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Memory problems
- Mood swings
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, lack of motivation
- Relationships problems (with friends, with relatives, or at work)
- School problems
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, identity issues
- Sleep problems (too much, too little, insomnia, nightmares)
- Spiritual, religious, moral, ethical issues
- Stress and tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolation
- Work problems, employment issues

SUBSTANCE USE HISTORY:

Have you ever experienced a problem with alcohol, drugs, or prescription medications? yes no

If yes, please explain: _____

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications? yes no

If yes, please explain: _____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? yes no If, yes, please explain: _____

Have you had any problems related to use of alcohol/drugs in the past year? yes no

If, yes, please explain: _____

Has drinking or drug use ever caused you problems in the following areas (check if yes):

family school employment legal emotional social financial behavior physical health

FAMILY BACKGROUND:

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN:

Names of Children	Living with you?	Age	Grade	School
1. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
2. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
3. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
4. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
5. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____

Other than any children already indicated above, who lives in your household? _____

Please describe your relationships with other family members:

Relationship	Living?	Describe quality of relationship
Father	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____
Mother	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____
Step-father	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____
Step-mother	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____
Spouse/partner	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____
Sister(s)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____
Brother(s)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____
Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____

Whom were you raised by? _____

Were you adopted? yes no If so, at what age? _____

What family member(s) were you closest to as a child?

What family members(s) are you closest to now? _____

Check the statement(s) below that describe the type of family you grew up in:

- overly close family no "breathing room" everyone was in everyone else's business no privacy
 boundaries not respected comfortably close family loving shared many positive experiences supportive
 distant, everyone did their own thing not much time spent together not a lot of support angry, lots of fighting/hostility
 verbal abuse and conflicts violence frightening scared to make mistakes

Have any biological relatives ever had any emotional problems or substance abuse? yes no

If yes, please explain: _____

Has anyone in your family ever attempted or committed suicide? yes no

If yes, please explain: _____

MARITAL STATUS:

Marital/relationship status (Check one) Married; Live with partner (check if same ___ or opposite ___ sex);
 Single; Separated/Divorced; Widowed; or Other: _____

Comments regarding stresses in current or previous marriage(s)/relationship(s): _____

If you have had problems in the past, what do you think caused those relationships to end? _____

Have you ever been abused mentally or physically by a romantic partner? yes no

Does this apply to your current relationship? yes no

Do you feel safe? yes no

EMPLOYMENT/EDUCATION INFORMATION:

Check all that apply: employed retired disabled student homemaker unemployed

If/When employed, what type of work do you do? _____

Current employer is: _____ Years on current job: _____

Your income: _____ Total household income: _____

Highest degree completed in school: _____

HEALTH/MEDICAL INFORMATION:

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____

Do any of these problems affect your everyday life? yes no If yes, how so? _____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): _____

Have you ever blacked out / lost consciousness and/or experienced any type of serious head injury or trauma? yes no
If so, please indicate when and what happened.

List all medications that you currently use:

Medication(s) _____

Dosage (amount and times per day) _____

Reason(s) _____

Name of Medication Prescriber: _____

Name of Primary Care Physician (PCP): _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship _____

Address _____
(Street, Apt #) (City) (State) (Zip Code)

Telephone # Daytime _____ Evening _____

Cell Phone _____