Adult Intake Form

Name: _____ Date: _____

Emergency Contact

Name: _____ Relationship to you: _____

Home Phone: _____ Alternate Phone: _____

Home Address: _____

City: _____ State: ____

Zip Code: _____

Chief Concern

Reason for seeking therapy:

_____

_____

_____

_____

What was the event that triggered this issue?

_____

_____

_____

_____

Does anything make the issue better or worse? Yes No

*created by Riley Southerland, Intern, August 2020

If you answered yes, please explain what makes the problem better or worse:

_____

_____

_____

_____

Rate the intensity of the Presenting Problem:	1	2	3	4	5
	Not Bad				Very Bad
Please rate your overall health:	1	2	3	4	5
	Poor				Great

For the following questions, please rate your concern on a scale from 1 to 5, with 1 being not concerned at all and 5 being extremely concerned.

Energy Level (high or low energy constantly)	1	2	3	4	5
Sleep Disturbance	1	2	3	4	5
Appetite Changes	1	2	3	4	5
Amount of Exercise	1	2	3	4	5
Anger/Hostility	1	2	3	4	5
Poor Concentration	1	2	3	4	5
Irritability/Agitation	1	2	3	4	5
Mood Swings	1	2	3	4	5
Obsessive Thoughts	1	2	3	4	5

Compulsions	1	2	3	4	5
Anxiety/Tension	1	2	3	4	5
Memory Problems	1	2	3	4	5
Fearfulness	1	2	3	4	5
Hallucinations	1	2	3	4	5
Paranoid Thoughts	1	2	3	4	5
Depressed Mood	1	2	3	4	5
Hopelessness	1	2	3	4	5
Suicidal Thoughts	1	2	3	4	5
Homicidal Thoughts	1	2	3	4	5
Family/Friend Support	1	2	3	4	5
Social Isolation	1	2	3	4	5
Violent Behavior	1	2	3	4	5
Arrests	1	2	3	4	5
Legal Issues	1	2	3	4	5

Have you ever been to therapy before? Yes No

If you answered yes…

With whom did you go to therapy? _____

What were the dates? _____

What was your diagnosis? _____

Have you ever been hospitalized for psychiatric issues? Yes No

*created by Riley Southerland, Intern, August 2020

If you answered yes…

Where were you hospitalized? _____

When were you hospitalized? _____

How long were you hospitalized for? _____

Do you drink anything with caffeine? Yes No

If so, how much? _____

Do you smoke? Yes No

If so, how many times a day? 1-2 3-4 5-6 7-8 9-10 More than 10

Do you drink alcohol? Yes No

If so, how often do you drink? _____

What is the amount you consume each time you drink? _____

When did you last drink? _____

Do you use drugs? Yes No

If so, what type(s) of drugs do you use? _____

How much do you use this drug? _____

When was the last time you used this drug? _____

Current Medications

Name	Dosage/Frequency	Date Began	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any medical issues that I need to be aware of?

_____

_____

_____

_____

Family History

Have any members of your family ever had any of the following problems? Please include parents, grandparents, uncles, aunts, brothers, sisters, and children if applicable.

Depression	Yes	No
Anxiety	Yes	No
Manic Depression/Bipolar	Yes	No
Suicide Attempt	Yes	No
Completed Suicide	Yes	No
Learning Disability	Yes	No
Schizophrenia	Yes	No
Alcohol Abuse	Yes	No
Drug Abuse	Yes	No

Is there anything else you would like for me to know prior to starting therapy?

_____

_____

I look forward to working with you!

Martha R. Durham, PhD