

ADULT INTAKE FORM

Today's Date: _____

Name: (First) (M.I.) (Last)	Birth date:	Age:
Marital Status:	Sex Male Female	
In Case of Emergency, please contact:	Phone:	Relationship:

Please give a brief description of why you are seeking treatment: _____

Who referred you to our clinic? _____

1. FAMILY HISTORY

Your Mother's Name: _____ Age: _____ Occupation: _____ Education level: _____

Your Father's Name: _____ Age: _____ Occupation: _____ Education level: _____

Your Sibling(s): Age: _____ Sex: _____

Sex: _____

Were you adopted? Yes No

Has there been any abuse in your history? None Physical Verbal/Emotional Sexual

Describe any *family history* of mental health or chemical dependency problems or treatment: _____

List any involvement with social services, court system or legal services: _____

If applicable, your spouse/partner's name: _____ Age: _____ Occupation: _____

If applicable, list name, ages, and sex of each of your children: _____

If applicable give date(s) of your marriage, separation(s) and/or divorce: _____

List current members in your household: _____

2. EDUCATION AND WORK HISTORY

Education (highest level obtained): _____ Current Employer: _____

How long employed there? _____ Occupation: _____

If you have been in the military, please list dates, rank and type of discharge: _____

3. CHEMICAL USE HISTORY

Do you use tobacco products? Yes No If yes, type _____ quantity per day _____

Do you drink caffeine? Yes No If yes, type _____ quantity per day _____

Do you drink alcohol? Yes No If yes, usual number of drinks per day _____

Usual number of drinks per week _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself . or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite . being fidgety or restless . moving around a lot	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

For items 1-9, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

For items 1-9, when did you first notice these problems? _____

Please check the boxes of all other problems that you've had during *this last month*. Then, on the line that follows each problem tell us when you first noticed these problems.

- 10. Worrying and feeling nervous much of the time _____
- 11. Fears of crowds or having to talk to people _____
- 12. Feeling panic, heart pounding, feel like I'm losing it, I can't stand it _____
- 13. Can't get to sleep, or stay asleep _____
- 14. Sudden horrible memories or bad nightmares _____
- 15. Feeling that I have to do or think something over and over _____
- 16. Worrying a lot about germs, diseases, my health _____
- 17. Easily irritated and angry _____
- 18. Wanting to get revenge or hurt other people _____
- 19. Thoughts racing faster than I can follow them _____
- 20. Very extreme happiness or ambition _____
- 21. Hearing voices in my head or other strange experiences _____
- 22. Feeling like people are following me, monitoring me, or plotting to hurt me somehow _____
- 23. Out of control spending or gambling _____
- 24. Using drugs or drinking too much _____
- 25. Out of control eating _____
- 26. Dieting too much, or using laxatives or vomiting to lose weight _____
- 27. Concerns about sex _____
- 28. Frequent headaches, loss of balance, numbness, or sudden vomiting (circle which ones) _____
- 29. Frequent, constant, and/or extreme pain _____
- 30. Other problems: _____