ADULT INTAKE FORM

The therapy and counseling work we do is unique to you, just as it is to each one of our clients. Before we get started, we need to collect some general information from you.

Name:_____ **Date of Birth:**_____

INSURANCE INFORMATION

PRIMARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

SECONDARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

MENTAL HEALTH HISTORY/STATUS

What is your reason for seeking mental health services?

Equity
ASSOCIATES

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ **YES** ☐ **NO**

If yes, when and where? _____

Have you ever had outpatient treatment by a psychiatrist? ☐ **YES** ☐ **NO**

If yes, when and by whom? _____

Have you ever received counseling or psychotherapy in the past? ☐ **YES** ☐ **NO**

If yes, when and by whom? _____

Please List any psychiatric medication you have taken or are taking:

Medication	**Date**	**Side Effects/Benefits**

Please Check all that apply:

☐ Depressed mood	☐ Excessive talking	☐ Unreasonable fear
☐ Lost or gained weight	☐ Racing thoughts	☐ Fear of social situations
☐ Not enough sleep	☐ Easily distracted	☐ Repetitive thoughts/behavior
☐ Too much sleep	☐ Over working yourself	☐ Upsetting memories
☐ Sluggish	☐ Impulsive behavior	☐ Recent loss/grief
☐ Agitated	☐ See/hear things that are not real	☐ Work/school problems
☐ Never tired	☐ Suspect things may not be real	☐ Violent thoughts/behaviors
☐ Cannot concentrate	☐ Tense/unable to relax	☐ Self harm
☐ Afraid to leave home	☐ Excessive worry	☐ Anger outburst
☐ Inflated self-esteem	☐ Panic attacks	☐ Careless, high-risk behavior
☐ Feel guilty or worthless	☐ Thoughts of death or suicide	☐ Financial problems

GENERAL MEDICAL HISTORY

Primary Care Physician: _____

Please list any medical problems you may have below:

Please list any serious medical procedures you have had in the past:

Are you on any medications for any general medical problems you may have? ☐ **YES** ☐ **NO** If yes, which ones?

_____

Do you have any allergies to medications? ☐ **YES** ☐ **NO** If yes, which ones?

_____

Alcohol, Drug, and Tobacco Use

Describe your use of alcohol: _____

Describe your use of recreational drugs: _____

Describe your use of tobacco: _____

Family Medical History

List any history of illness (mental or other) and substance abuse among blood relatives:

Mother's side **Father's side**

SOCIAL HISTORY

Birth place: _____ Where did you grow up? _____

Did your parents get divorced as a child? ☐ **YES** ☐ **NO**

If so, how old were you when they separated? _____

Father's occupation growing up: _____

Mother's occupation growing up: _____

How many siblings do you have? _____

Did you have any early development problems as a child?

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Highest Level of Education: _____

Please list the last three jobs you have had below:

Current employment: _____

Are you currently in a romantic relationship? ☐ **YES** ☐ **NO** Duration: _____

Describe your relationship:

Spouse or partner's current occupation: _____

Do you have any children? ☐ **YES** ☐ **NO** How many? _____

What are your children's names and ages?

What activities do you enjoy doing?

Have you ever been convicted of any crimes, served time, or been on probation? ☐ **YES** ☐ **NO**

Details: _____

Please list any additional notes that you think would be helpful for treatment below: