

## **Intake Form**

Name:		D	ate:
PRE	SENTING ISSUES AND CO	ONCERNS	
Describe what brought you here tod	ay:		
Please check all of the behaviors ar  Distractibility Hyperactivity Impulsivity Boredom Poor memory/confusion Seasonal mood changes Sadness/depression Loss of pleasure/interest Hopelessness Thoughts of death Self-harm behaviors Crying spells Loneliness Low self worth Guilt/shame Fatigue Other:	nd symptoms that you conside Change in appetite Lack of motivation Withdrawal from people Anxiety/worry Panic attacks Fear away from home Social discomfort Obsessive thoughts Compulsive behavior Aggression/fights Frequent arguments Irritability/anger Homicidal thoughts Flashbacks Hearing voices Visual hallucinations	Susp Raci Raci Side Nide Slee Nigh Eatir Gam Prob Prob Rela Nela	picion/paranoia ng thoughts essive energy e mood swings p problems tmares ng problems bling problems puter addiction lems with pornography nting problems tal problems tionship problems tionship problems hol/drug use urring, disturbing memories
Are your symptoms/issues affecting  Handling everyday tasks  Work/School Recreational activities  Yes No Have you ever ha	☐ Self esteem ☐ R☐ Housing ☐ L	Relationships egal matters lealth or attempted to h	☐ Hygiene☐ Finances urt yourself? If yes,
	d thoughts, made statements,	•	urt someone else? If yes,
•	been physically hurt or threat		else? If yes,
☐ Yes ☐ No Have you e	ed in the past 6 months? If yewer felt the need to bet more a ver had to lie to people importa	nd more money?	-
Therapist Notes:			

Name:		
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## **FAMILY AND DEVELOPMENTAL HISTORY**

			1	T -			<del></del>			
Relati	onship	Name	Age	Quality of		Family Mental Health	Who?			
Mothor				Relationship		Problems				
Mother Father					_	Hyperactivity Sexually Abused				
Stepmo	thor		_			Depression				
Stepfilo			_			Bipolar				
Siblings					-	Suicide				
Sibilligs					-					
					-	Anxiety Panic Attacks				
						Obsessive-Compulsive				
Spouse	/nartner					Anger/Abusive				
Children					-	Schizophrenia				
Crinarei	<u> </u>					Eating Disorder				
					-	Alcohol Abuse				
					Drug Abuse					
						Drug Abuse				
Pare Please of Emore Sexue Physe Pare Teen	nts tempo nts divorce	ce abuse Sy	eparated any of the Neg Viol Crin	☐ Fa	ther s of	trauma or loss:  Lived in a foster  Multiple family m Homelessness Loss of a loved of	noves			
							Init:			
		<u>PREVI</u>	OUS ME	NTAL HEALT						
Yes No		of Treatment	When?	Provider/Prog	ram	Reason for Tre	eatment			
	Outpatie	nt Counseling								
	Medication	on (mental health)								
		,								
	Psychiat	ric Hospitalization								
	Drug/Alc	ohol Treatment								
	Self-help	/Support Groups								
<u> </u>		l		ı		l				
Therap	ist Notes:									
							Init:			

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## **SUBSTANCE USE HISTORY**

Substance Type	ubstance Type Current Use (last 6 months) Past Use									
Oubstance Type	Υ	N	Frequency	Amo		Υ	N	Freque		Amount
Tobacco	<u>'</u>	1 4	Trequency	Airio	dit	<u> </u>	11	Treque	oricy	Amount
Caffeine										
Alcohol										
Marijuana Casaina/araak										
Cocaine/crack										
Ecstasy										
Heroin										
Inhalants										
Methamphetamines										
Pain Killers										
PCP/LSD										
Steroids										
Tranquilizers										
☐ Yes ☐ No Have yo describe ☐ Yes ☐ No Have substance use? If yes,	you	eve	r had problems w	vith worl	k, relationshi	ips, h	nealth	n, the la	w, etc. due	
Therapist Notes:										
										Init:
										<u></u>
MEDICAL INFORMATION										
Date of last physical ex	am:									
Have you experienced any of the following medical conditions during your lifetime?  Allergies Asthma Headaches Stomach aches  Chronic pain Surgery Serious accident Head injury  Dizziness/fainting Meningitis Seizures Vision problems  High fevers Diabetes Hearing problems Miscarriage  Sexually transmitted disease Abortion Sleep disorder Other:  Please list any CURRENT health concerns										
Current prescription me	diaa	tion	□ None							
Medication me	Current prescription medications: None  Medication Dosage Date First Prescribed Prescribed By						scribed Rv			
Medication			Dosage		Date i ii	SUFI	CSCII	beu	r i e	scribed by
Current over-the-counter medications (including vitamins, herbal remedies, etc.):										
Allergies and/or adverse reactions to medications:  If yes, please list										
Therapist Notes:										
										Init:

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INTERPERSONAL/SOCIAL/CULTURAL INFORMATION
Please describe your social support network (check all that apply):  Family Neighbors Friends Students Co-workers Support/Self-Help Group Community Group Religious/Spiritual Center (which one?
To which cultural or ethnic group do you belong?
Please describe your strengths, skills, and talents?
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):
Therapist Notes:
Init:
MISCELLANEOUS INFORMATION
Employment Employment
Employer:Position
Education
Yes No Are you currently attending school?   High School Graduate? Or ☐ GED? Year   Associate's Degree Year Major area of study   ☐ Undergraduate Degree Year Major area of study   ☐ Graduate Degree Year Major area of study
Military Service
☐ Yes ☐ No Have you been/are you currently in the military? (If no, skip remainder of this section)
BranchDate of Discharge Type of Discharge Rank  Yes No Were you in combat?
Legal  Yes No Are you currently involved in any divorce or child custody proceedings? If yes, please explain
Therapist Notes:
Init:

Name: