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ADULT INTAKE ASSESSMENT FORM

Please answer all of the following questions to the best of your ability.

IDENTIFYING INFORMATION

Name: _____ Today's Date: ___/___/___

Male Female Date of Birth ___/___/___ Age: ___

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell/other phone: _____

RACE/ETHNICITY

	Self	Spouse
European-American	_____	_____
African-American	_____	_____
Hispanic-American	_____	_____
Native-American	_____	_____
Asian-American	_____	_____
White	_____	_____
Other _____	_____	_____

RELIGIOUS AFFILIATION

	Self	Spouse
Catholic	_____	_____
Jewish	_____	_____
Muslim	_____	_____
Protestant	_____	_____
Non-Denominational	_____	_____
Eastern (e.g., Hindu, Buddhist)	_____	_____
Other _____	_____	_____

MARITAL STATUS

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

If previously married, please provide dates of Marriage(s): _____

Number of years currently married: _____

Are you experiencing any problems/stresses in your current marriage/relationship? yes no Did you experience any problems/stresses in your previous marriage/relationship? yes no

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? _____

EDUCATION

Last grade completed in school/college is/was: _____ Degree: _____

Are you currently enrolled in school? yes no Major/focus: _____

Do you have any special training, skills, or certification? (list): _____

Do you have any problems reading or writing? yes no

Do you have any difficulty understanding (check any that apply): spoken instructions
 written instructions
 demonstrated instructions

How do you learn best? _____

What was school like for you? _____

Describe any difficulties or problems you had/have in school: _____

OCCUPATION/EMPLOYMENT INFORMATION

Check all that apply: employed retired disabled student homemaker unemployed If/When employed, what type of work do you do? _____

Current employer: _____ Years on Current Job: _____

Are you currently having difficulties on the job because of (Check if yes):
 emotional problems?
 substance abuse?

Have you ever had difficulties at work because of (Check if yes):
 emotional problems?
 substance abuse?

If yes to any of the above, please explain: _____

Ever in Military Service: yes no
Currently in military? yes no Branch: _____
If you served in combat, when did you serve? _____
Type of discharge: _____
Reason for discharge: _____

REASON FOR SEEKING

Please briefly describe the problems you are experiencing. A therapist will discuss this in more detail with you shortly. _____

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? _____

What do you consider to be the other stresses in your life? _____

HISTORY OF THE PROBLEM

When did you first start experiencing the problem(s) that bring you to the clinic today? _____

How often does the problem occur? _____

How long does it last? _____

Do you currently have thoughts of harming yourself? yes no

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: _____

- Do you have any problem with any of the following: overspending food binging
 intentional vomiting yelling/threatening risk taking/ endangering self or others
 hitting, shoving, choking, or hurting others throwing or breaking things
 stealing internet overuse or misuse sexual feelings/behaviors

Have you ever had previous therapy/counseling of any kind? yes no

If yes, when and for how long? _____

What concerns did you address in previous therapy? _____

Have you ever been hospitalized for emotional problems? yes no

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

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

Were any of your previous treatment experiences helpful? yes no

Please explain how you benefited or did not benefit from previous treatment: _____

What medication(s), if any, have you found helpful in managing your emotional problems? _____

Have you had any experience with self-help support groups? yes no

If yes, please explain when, which ones, and whether or not you found them helpful:

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 other, please describe: _____

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?	Frequency of contact?	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

Please list the age and sex for each of your brothers/sisters (including those deceased, and please indicate if any are step-siblings): _____

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

As you were growing up, what adult(s) stood out as people you could really trust? _____

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
- other descriptors: _____

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: _____

HEALTH/MEDICAL INFORMATION

Physician	Address & Telephone #	Approx Date of last visit
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 had a serious head injury? yes no If yes, describe: _____

Are you allergic to any medications? yes no If yes, which one(s): _____

HEALTH/MEDICAL INFORMATION (continued)

Please list any "alternative" therapies/treatments you are currently using and the reason for each:

Have you ever had or do you now have a problem with any of the following? (Check all that apply):

General

- | | | |
|--|---|---|
| <input type="checkbox"/> Recent Fever/Chills | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cigarette Smoking |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other Tobacco Use |
| <input type="checkbox"/> Frequent or Terrifying Nightmares | <input type="checkbox"/> Drug Reaction | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Insomnia or Sleep Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Suicide Attempt(s) |
| <input type="checkbox"/> Chronic Pain _____ | <input type="checkbox"/> Exposure to Trauma (Type: _____) | |

Gastrointestinal/Hepatic/Endocrine

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Colitis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Always Thirsty |
| <input type="checkbox"/> Gall Bladder/Stones | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Low Blood Sugar |

Musculoskeletal

- Broken Bones
- Bad Back
- Herniated Disk
- Muscle Weakness
- Joint Pain
- Arthritis
- Gout

Cardiovascular

- Angina
- Fainting
- Lightheadedness
- Irregular Heart Beat
- High/Low Blood Pressure
- Rheumatic Fever
- Heart Valve Problems

Pulmonary

- Chest Pains/Pressure
- Shortness of Breath
- Cough
- Wheezing/Asthma
- Coughing Blood
- Tuberculosis
- Pneumonia

Neurological

- Headaches
- Migraines
- Skull Fracture
- Epilepsy
- Stroke
- Paralysis
- History of Head Injury
- Double Vision
- Memory Loss
- Unsteady Gait

Urinary/Genital

- Frequent Urination
- Burning on Urination
- Weak Urinary System
- Incontinence
- Urinary Tract Infection
- Blood in Urine
- Kidney Infection
- Penis/Vaginal Discharge
- Menstrual Difficulties
- Sexual Difficulties
- STD

Skin/Sensory Systems

- Sores/Abscesses
- Skin Rash
- Eye Trouble
- Hearing Loss
- Ringing in Ears
- Perforated Septum
- Nose Bleeds
- Gum Bleeding
- Mouth Sores
- Difficulty Swallowing

INTERESTS AND ACTIVITIES

Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently: _____

Please describe your personal strengths and positive characteristics: _____

Other information you feel is important and wasn't asked about: _____

IN CASE OF EMERGENCY

<u>Name(s)</u>	<u>Relationship to Client</u>	<u>Telephone No.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____