

Intake Form

Name:	Dat	Date:			
Presenting Problems and Concerns					
Describe the problem that brought you here today:					
When did it start and how	does it affect you:				
Estimate the severity of the Severe	e above problem: Mild - Modera	te - Severe - Very			
Please check all of the beha	aviors and symptoms that you co	nsider problematic:			
DistractibilityHyperactivityImpulsivityBoredomPoor memoryPhobiasCompulsive behaviorsHopelessnessSelf-harm behaviorsGuilt/ShameEating problemsComputer addictionParenting problemsHomicidal thoughtsRelationship problemsVisual hallucinations	Change in appetiteLack of motivationIsolationAnxiety/WorryPanic attacksObsessive thoughtsSadness/DepressionHelplessnessLonelinessFatigueGambling problemsProblems with pornographyFrequent argumentsFlashbacksWork/School problemsOther	ParanoiaRacing thoughtsToo much energyMood SwingsSocial discomfortSleep problemsLoss of pleasureThoughts of deathLow self-esteemNightmaresAggression/FightsSexual ProblemsIrritability/AngerAlcohol/Drug useHearing voices			
Are your problems affectin _Work/School _Hygiene _Finances _Health	_Self-esteemR _HousingL	elationships egal matters exual activity			



Have you ever had t	_	ients, or atter	npted to hurt yourself? _YES
-	thoughts, made statemes, please describe:	ients, or atter	npted to hurt someone else?
	Family and Deve	lopmental H	listory
Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			
Family Mental	Health Problems		Who?
Depression			
Anxiety			
Panic Attacks			
Obsessive-Compuls			
Eating Disorders/D	isordered Eating		
Hyperactivity			
Sexually Abused			
Bipolar			
Anger/Abusive			
Alcohol Abuse			
Substance Abuse			



Schizophrenia	
Completed Suicide	
Psychiatric Hospitalizations	
_Parents legally married or living togethe _Parents temporarily separated	rMother remarried: # of times Father remarried: # of times
	Lived in a foster home he homeMultiple family homesHomelessness
Past/Present Psychotherapy (specify: mor number of sessions, initial reason for there ended:	
1)	
2)	
3)	
Medical In	formation
Name of Primary Care Physician: Date of last physical exam: Have you experienced any of the following	
_AllergiesAsthma	_HeadachesStomach aches
_Chronic pain _Surgery _Dizziness/fainting _Meningitis	_Serious accident _Head injury _Seizures _Vision problems



_High fevers _STDs	_Diabetes _Abortion			_Hearing problems _Sleep disorders		_Miscarriage _Other		
Please list any CURRI	ENT hea	alth c	concern	S:				
Current prescription	medica	tions	s:Nc	one				
Medication	Dosage		Date First Prescribed		Prescribed By			
Current over-the-cou							al remed	ies, etc.):
e ,								
If yes, please list:								
		Su	bstanc	e Use Histor	y			
Substance Type	Current Use (last 6 mos.) Past Use						se	
	Y	N	Freq	Amount	Y	N	Freq	Amount
Tobacco								
Caffeine								
Caffeine Alcohol								
Caffeine Alcohol Marijuana								
Caffeine Alcohol								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin Inhalants								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin Inhalants Methamphetamines								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin Inhalants Methamphetamines Pain Killers								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin Inhalants Methamphetamines Pain Killers LSD								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin Inhalants Methamphetamines Pain Killers LSD PCP								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin Inhalants Methamphetamines Pain Killers LSD PCP Steroids								
Caffeine Alcohol Marijuana Cocaine/Crack Ecstasy Heroin Inhalants Methamphetamines Pain Killers LSD PCP								



Have you ever had problems with work, relationships, health, the law, etc., due to your substance use? _YES _NO If yes, please describe:
Interpersonal/Social/Cultural Information
Please describe your social support network (check all that apply): _Family _Neighbors _Friends _Co-workers _Community Group _Religious/Spiritual Center
To which cultural or ethnic group do you belong?
How important are spiritual matters to you?Not at allLittleSomewhatVery much
Describe any special areas of interest or hobbies:
Additional Information
Employer: Position:
Stress level of this position: _LowMediumHigh
Education Are you currently attending school? _YesNo _High School Graduate? _GED Year College Degree Year Major
Military Service Have you been/are you currently in the military?YesNo Branch Date of Discharge Type of Discharge Rank
Were you in combat? _Yes _No
<u>Legal</u> Have you ever been convicted of a misdemeanor or felony? _Yes _No If yes, please explain



Are you currently involved in any divorce or child custody proceedings? _Yes _No
What gives you the most joy or pleasure in your life?
What are your most important hopes or dreams?
Additional Comments: