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Intake History for Adults

The purpose of this questionnaire is to obtain your medical, mental health, family and personal history. This information will help you assess your own situation and help me determine your therapy needs. Please answer as accurately, completely and honestly as possible.

DOB:___________ Age: _________ Birthplace: City_______________________ State __________

Any birth/developmental complications? ____

Education: High School_____________________________ Date Graduated___________________

College(s)____ Date Graduated___________________

Work: Most recent place of employment ______________________________ No. years __________

Military experience: Branch_______________ Rank________________ Separation date_________

Current relationship status and relationship history: *(check current status & provide all dates as they apply)*

☐ Single	☐ Married (year: _____)	☐ Separated (year: _____)
☐ Partnered/engaged (year: _____)	☐ Widowed (year: _____)	☐ Divorced (year: _____)

Who lives with you in your home? *(check all that apply)*

☐ Live alone	☐ Spouse or partner	☐ Roommate(s)
☐ Biological children	☐ Stepchildren	☐ Foster children
☐ Grandchildren	☐ Children's siblings	☐ Nieces/nephews
☐ Parents or grandparents	☐ Your siblings	☐ Other:______________________
☐ Other family members	☐ International/exchange students	☐ Pets

Total number of children under age 18 who currently live with you: **Ages:** _____________

Primary Care Physician: Name: Clinic Affiliation: Address: Phone:	**Psychiatrist?** ☐**Yes** ☐**No** If yes, Name: Address: Phone:
Have you ever had therapy or counseling? ☐**Yes** ☐**No** If yes, provide name of *most recent* therapist and date(s) of service: Name: Clinic or Office: Address: Phone: Date(s) of service:	**Have you ever been hospitalized for mental illness, emotional distress, or suicide attempt?** ☐**Yes** ☐**No** If yes, provide dates, hospitals, and reasons:

List all prescription medications you are currently taking:

Name of medication | Dosage or instructions

1.
2.
3.
4.
5.
6.

List all "over the counter" medicines, herbal remedies, vitamins or supplements you are currently taking:

Name of medication, remedy, vitamin, supplement | Dosage or instructions

1.
2.
3.
4.
5.
6.

Indicate alternative therapies: *(check all that apply)*

☐ Chiropractic
☐ Massage
☐ Acupuncture
☐ Other, please specify:

Health Habits:

How often do you smoke?

☐ I don't smoke, never did
☐ I don't smoke any more
☐ Less than a pack a week
☐ About a pack a day
☐ More than a pack a day

If you smoke, would you like to quit?
☐ Yes ☐ No

How often do you drink alcoholic beverages?

☐ I don't drink at all
☐ Rarely drink or only on special occasions
☐ I drink less than three a week
☐ I drink one or two a day
☐ I drink more than two a day
☐ I have more than five drinks in one sitting once a week or more often

Has your drinking ever caused any problems?
☐ Yes ☐ No

Has anyone ever asked you to quit drinking?
☐ Yes ☐ No

Have you ever tried to cut down on your drinking?
☐ Yes ☐ No

How often do you drink caffeinated beverages (coffee, tea, soda, etc.)?

☐ None at all
☐ 1-6 servings per week
☐ 1-4 servings per day
☐ 5-8 servings per day
☐ more than 8 servings per day

Preferred Beverages:________________________________

How often do you use recreational drugs?

☐ I never use recreational drugs
☐ A few times a year on special occasions
☐ About once a week
☐ More than once a week

I have tried the following drugs:

☐ pot (marijuana)
☐ ecstasy
☐ speed or cocaine
☐ LSD
☐ heroin
☐ oxycontin or other prescription drugs
☐ methamphetamine
☐ other (please specify: ____________________________)

How often do you get at least 20 minutes of exercise?

☐ Rarely
☐ 1-2 times per week
☐ 3-4 times per week
☐ 5-7 times per week
☐ More than once per day

What kind of exercise?

How would you describe your sleep? *(check all that apply)*

☐ Sleep is never a problem for me
☐ Hard time falling asleep occasionally
☐ Hard time falling asleep most nights
☐ Hard time staying asleep most nights
☐ Wake up before alarm most days
☐ Take naps on a regular basis
☐ Nod off frequently and have a hard time staying awake

Do you ever feel jittery or shaky? ☐ Yes ☐ No

Hobbies?

What helps you manage your stress most effectively?

Do you have or have you ever had any of the following medical conditions? (*check all that apply)*

☐ Overweight/underweight	☐ Eating concerns (over/under)	☐ Bariatric surgery
☐ Digestive problems	☐ Joint problems	☐ Sleep problems
☐ Sexual functioning problems	☐ Reproductive problems	☐ Chronic pain
☐ Vision or hearing impairment	☐ Seizures	☐ Fainting/dizziness
☐ Numbness or tingling	☐ Nausea	☐ Muscle weakness
☐ High blood pressure	☐ Heart/lung disease	☐ Diabetes
☐ Thyroid/endocrine function	☐ Blood diseases/anemia	☐ Immune system disease
☐ Headaches	☐ Migraine	☐ Fatigue (excessive or chronic)
☐ Tremor, neuropathy, paralysis	☐ Forgetfulness	☐ Cancer
☐ Head injury	☐ Sports-related injury	☐ Work-related injury

Please describe *<u>any other physical health concerns</u>*:

Does your family of origin have a history of any of the following? *(check all that apply)*

☐ Schizophrenia or psychosis	☐ Anxiety or panic disorder	☐ Depression
☐ Developmental delays/disorders	☐ Alcohol or drug abuse	☐ Extreme poverty or homelessness
☐ Bipolar or manic/depressive disorder	☐ Violence or criminal behavior	☐ Suicide

Do you or have you ever done any of the following? *(check all that apply)*

☐ Had temper outbursts	☐ Thrown things when angry	☐ Physically fought with someone
☐ Been suspended or expelled from school?	☐ Had thoughts of inflicting injury on others	☐ Planned or plotted against someone?
☐ Been charged with domestic violence or disorderly conduct	☐ Had any underage drinking tickets	☐ Had one or more DUI or OWI
☐ Relieved tension by cutting or hurting self	☐ Had thoughts of suicide	☐ Attempted suicide
☐ Spent time in jail or prison	No. Years ______ Charges: ________________________________	

Do you, or does anyone in your household, own a gun? ☐ Yes ☐ No

What methods do you use to assure gun safety in your home?

Your life experiences: *(check all that apply, include past and current for both home and work)*

☐ Relationship problems	☐ Family problems	☐ Social problems
☐ Unhappy childhood	☐ Adopted as a child or spent time in foster care	☐ Death of spouse
☐ Death of parent	☐ Death of child	☐ Death of friend or other loved one
☐ Put a child into foster care or lost custody	☐ Unplanned pregnancy with adoption or abortion	☐ Natural disaster
☐ War (as a civilian)	☐ Active military duty	☐ Frequent job loss or change
☐ Bullied in workplace	☐ Sexual harassment based on gender or sexual preference	☐ Rape/sexual assault
☐ Victim of other violent crime	☐ Witness to violent crime or traumatic fatality	☐ Witnessed sexual abuse
☐ Witnessed emotional abuse	☐ Witnessed physical abuse	☐ Experienced sexual abuse
☐ Experienced emotional abuse	☐ Experienced physical abuse	☐ In violent partnership or marriage
☐ Caregiver for special needs child or ailing family member	☐ Poverty or homelessness as head of household	☐ Bankruptcy, foreclosure, eviction
☐ Other—please specify:		

What is the major reason you are seeking service at this time?

What are your special strengths or talents?

What are your current goals in life?

How would you like to be remembered at the end of your life?

Print or Type Name: ____

Signature: ____

Today's date: ____________________