ADULT INTAKE ASSESSMENT FORM

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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: _____
Is it OK to contact you at home? ☐Yes ☐No OK to leave a message? ☐Yes ☐No
Special calling instructions? _____

Business phone: _____
Is it OK to contact you at work? ☐Yes ☐No OK to leave a message? ☐Yes ☐No
Special calling instructions? _____

How did you learn about my services? _____

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: _____

MARITAL STATUS

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

MARITAL STATUS (continued)

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: _____
_____
_____

REASON FOR SEEKING TREATMENT

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 current 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: _____
_____
_____
_____

SUBSTANCE USE HISTORY (continued)

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. _____	☐yes ☐no	_____	_____	_____
2. _____	☐yes ☐no	_____	_____	_____
3. _____	☐yes ☐no	_____	_____	_____
4. _____	☐yes ☐no	_____	_____	_____
5. _____	☐yes ☐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 yes no n/a _____
Mother yes no n/a _____
Step-father yes no n/a _____
Step-mother yes no n/a _____
Spouse/partner yes no n/a _____
Sister(s) yes no n/a _____
Brother(s) yes no n/a _____
Other_____ yes no n/a _____

Whom were you raised by? _____ Were you adopted? yes no
Please list the age and gender for each of your brothers/sisters (including those deceased, and please indicate if any are step-siblings): _____
_____
_____

FAMILY BACKGROUND (continued)

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: _____
_____

RACE/ETHNICITY

	Self	Spouse
European-American	_____	_____

RELIGIOUS AFFILIATION

	Self	Spouse
Catholic	_____	_____

African-American	_____	_____	Jewish	_____	_____
Hispanic-American	_____	_____	Muslim	_____	_____
Native-American	_____	_____	Protestant	_____	_____
Asian-American	_____	_____	Non-Denominational	_____	_____
Other _____	_____	_____	Eastern (e.g., Hindu, Buddhist)	_____	_____
			Other _____	_____	_____

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.):
_____
_____

HEALTH/MEDICAL INFORMATION (continued)

Have you ever had a serious head injury? ☐yes ☐no If so, describe: _____
_____
_____

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

List all medications that you currently use:

Medication(s)	Dosage (amount and times per day)	Reason(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

☐Recent Fever/Chills	☐Diabetes	☐Cigarette Smoking
☐Chronic Fatigue	☐Cancer	☐Other Tobacco Use

☐ Frequent or Terrifying Nightmares ☐ Drug Reaction ☐ Alcohol Use
☐ Night Sweats ☐ Emotional Problems ☐ Drug Use
☐ Insomnia or Sleep Problems ☐ Allergies ☐ Suicide Attempt(s)
☐ Chronic Pain ☐ Exposure to Trauma (Type: _____)

Gastrointestinal/Hepatic/Endocrine

☐ Nausea ☐ Hepatitis ☐ Weight Loss/Gain
☐ Gastritis ☐ Constipation ☐ Change in Appetite
☐ Ulcers ☐ Diarrhea ☐ Anemia
☐ Vomiting Blood ☐ Colitis ☐ Thyroid Problems
☐ Pancreatitis ☐ Rectal Bleeding ☐ Always Thirsty
☐ Gall Bladder/Stones ☐ Hemorrhoids ☐ Swollen Glands
☐ Jaundice ☐ Liver Problems ☐ Low Blood Sugar
☐ Gallbladder/Stones ☐ Hemorrhoids
☐ Jaundice ☐ Liver Problems

Musculoskeletal | Cardiovascular | Pulmonary

☐ Broken Bones ☐ Angina ☐ Chest Pains/Pressure
☐ Bad Back ☐ Fainting ☐ Shortness of Breath
☐ Herniated Disk ☐ Lightheadedness ☐ Cough
☐ Muscle Weakness ☐ Irregular Heart Beat ☐ Wheezing/Asthma
☐ Joint Pain H ☐ High/Low Blood Pressure ☐ Coughing Blood
☐ Arthritis ☐ Rheumatic Fever ☐ Tuberculosis
☐ Gout ☐ Heart Valve Problems ☐ Pneumonia

HEALTH/MEDICAL INFORMATION (continued)

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: _____

_____

_____

Thank you for your time and cooperation.

Jason G. Stentoumis, Psy.D.