ADULT INTAKE ASSESSMENT FORM

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

IDENTIFYING INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____

Cell Phone: _____ Home and/or work phone (optional) _____

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

Race/Ethnicity (please check all that apply):

European-American ☐
African-American ☐
Hispanic-American ☐
Native-American ☐
Asian-American ☐
Other _____ ☐

Assigned Gender (gender assigned at birth): ☐ Male ☐ Female

Gender Identity: ☐ Female ☐ Male ☐ Transgender Male/FTM ☐ Transgender Female/MTF

☐ Non-binary/Genderqueer ☐ Other_____

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight/Heterosexual ☐ Bisexual

☐ Other _____ ☐ Choose not to disclose

Please indicate, if any, your religious affiliation and/or faith-based community?

_____

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?

Ever serve in the U.S. Military? ☐ Yes ☐ No If yes, Branch: _____

Currently in military? ☐ Yes ☐ No If yes, Branch:_____

If you served in combat, when did you serve? _____

Type of discharge: _____ Reason for discharge: _____

EDUCATION

Last grade completed in school/college: _____ 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 academic and/or learning difficulties you have experienced: _____

_____

Have you ever received special education services? ☐ Yes ☐ No

MARITAL STATUS

Marital/relationship status (check one):

☐ Married ☐ Live with partner (check if same ☐ or opposite☐ sex)
☐ Single ☐ Separated/Divorced ☐ Widowed ☐ Other: _____

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/relationships? ☐ Yes ☐ No

Comments regarding stresses in **current** marriage/relationship:

_____

If previously married, please provide dates: _____

_

REASON FOR SEEKING TREATMENT/EVALUATION

Please briefly describe the problems you are experiencing.

_____

_____

Why are you seeking help now? _____

_____

What do you hope to be able to do or achieve as a result of evaluation and/or treatment?

_____

HISTORY OF EMOTIONAL AND/OR BEHAVIORAL DIFFICULTIES

When did you first start experiencing the problem(s) that you described above? _____

_____

How often does the problem(s) occur? _____

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 previously attempted suicide? ☐ Yes ☐ No

If yes, please explain: _____

_____

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

_____

Have you ever been a victim of abuse? ☐ Yes ☐ No

If yes, please check all that apply: ☐ emotional abuse ☐ physical abuse ☐ sexual abuse

Do you have any problem with any of the following:

☐ overspending
☐ risk taking/endangering self or others
☐ throwing or breaking things
☐ internet overuse or misuse
☐ food binging
☐ other: _____
☐ intentional vomiting
☐ hitting, shoving, choking, or hurting others
☐ stealing
☐ sexual feelings/behaviors
☐ yelling/threatening

Have you ever received previous therapy/counseling for emotional and/or behavioral concerns?

☐ Yes ☐ No

If yes, **when** and for **how long**? _____

_____

What concern(s) did you address in your prior treatment? _____

_____

Have you ever been hospitalized for emotional and/or behavioral difficulties? ☐ 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

Have you participated in self-help, support groups, etc. (i.e., Alcoholics Anonymous)? ☐ Yes ☐ No

If yes, please explain: _____

SUBSTANCE USE HISTORY

Have you ever experienced a problem with any of the following? (please check all that apply):

☐ alcohol ☐ marijuana ☐ prescription medications ☐ heroin ☐ cocaine

☐ tobacco ☐ other_____

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

Have you ever received treatment for problems with alcohol, drugs, or abuse of 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 ever received inpatient and/or residential substance abuse treatment? ☐ Yes ☐ No

If yes, please explain: _____

_____

FAMILY BACKGROUND

Please check this box if you have **no** children ☐

Names of children	Living with you?	Age
1. _____	☐ Yes ☐ No	_____
2. _____	☐ Yes ☐ No	_____
3. _____	☐ Yes ☐ No	_____
4. _____	☐ 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	_____	☐ Positive ☐ Neutral ☐ Strained ☐ Estranged
Mother	☐ Yes ☐ No	_____	☐ Positive ☐ Neutral ☐ Strained ☐ Estranged
Step-father	☐ Yes ☐ No	_____	☐ Positive ☐ Neutral ☐ Strained ☐ Estranged
Step-mother	☐ Yes ☐ No	_____	☐ Positive ☐ Neutral ☐ Strained ☐ Estranged
Spouse/partner	☐ Yes ☐ No	_____	☐ Positive ☐ Neutral ☐ Strained ☐ Estranged
Sister(s)	☐ Yes ☐ No	_____	☐ Positive ☐ Neutral ☐ Strained ☐ Estranged
Brother(s)	☐ Yes ☐ No	_____	☐ Positive ☐ Neutral ☐ Strained ☐ Estranged

Who raised you? _____ 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): _____

_____

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
☐ everyone was in everyone else's business
☐ no "breathing room"
☐ no privacy

☐ boundaries not respected
☐ loving
☐ supportive
☐ not much time spent together
☐ angry, lots of fighting/hostility
☐ violent
☐ scared to make mistakes
☐ comfortably close family
☐ shared many positive experiences
☐ distant, everyone did their own thing
☐ not a lot of support
☐ verbal abuse and conflicts
☐ frightening
☐ other descriptors: _____

Have any of your biological relatives ever suffered from psychological problems? ☐ Yes ☐ No

Has anyone in your immediate and/or extended family **attempted** suicide? ☐ Yes ☐ No

Has anyone in your immediate and/or extended family **completed** suicide? ☐ Yes ☐ No

HEALTH/MEDICAL INFORMATION

Primary Care Physician Approximate 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 and/or hospitalizations** for serious illness or injuries (what, where, when, etc.):

_____

_____

Have you ever had a head injury that resulted in a loss of consciousness? ☐ Yes ☐ No

If yes, describe: _____

_____

Please list all current medications:

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

_____

_____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, which one(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
- ☐ Chronic Fatigue
- ☐ Frequent Nightmares
- ☐ Night Sweats
- ☐ Insomnia or Sleep Problems
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Cancer
- ☐ Allergies

Substance Use
- ☐ Cigarette Smoking
- ☐ Other Tobacco Use
- ☐ Alcohol Use
- ☐ Drug Use

Gastrointestinal/Hepatic/Endocrine
- ☐ Nausea
- ☐ Gastritis
- ☐ Ulcers
- ☐ Thyroid Problems
- ☐ Gall Bladder/Stones
- ☐ Hepatitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Low Blood Sugar
- ☐ Liver Problems
- ☐ Weight Loss/Gain
- ☐ Change in Appetite
- ☐ Anemia
- ☐ Pancreatitis

Musculoskeletal
- ☐ Broken Bones
- ☐ Bad Back
- ☐ Herniated Disk
- ☐ Muscle Weakness
- ☐ Joint Pain H
- ☐ 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
- ☐ Head injury/Skull Fracture
- ☐ Epilepsy/seizures
- ☐ Stroke
- ☐ Ringing in Ears
- ☐ Paralysis
- ☐ Double Vision
- ☐ Memory Loss
- ☐ Unsteady Gait

Urinary/Genital
- ☐ Frequent Urination
- ☐ Burning on Urination
- ☐ Weak Urinary System
- ☐ Incontinence
- ☐ Urinary Tract Infection
- ☐ Sexual Difficulties
- ☐ STD
- ☐ Menstrual Difficulties

Skin/Sensory Systems
- ☐ Sores/Abscesses
- ☐ Skin Rash
- ☐ Eye Trouble
- ☐ Hearing Loss

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 to consider for evaluation and/or treatment?

_____

_____

_____

Thank you for your time and cooperation.

Jason G. Stentoumis, Psy.D.