



Adult Psychosocial Intake Form

Please answer these questions to the best of your ability before your first visit. By completing this questionnaire, you make more time available to discuss your treatment issues with your therapist. All information will be kept confidential. If we did not leave you enough space for any of the questions, use the back of the page for more space. If you need help with this, please feel free to ask your therapist. Your therapist will use the information you provide for the basis of your treatment.

Presenting Problem

What is the main problem for which you are hoping to get help?

How much does this problem bother you? Circle a number.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Very little A little Pretty much Very much Couldn't be worse

Has your appetite, weight, or eating pattern changed since this problem started? Yes [] No [] If so, how?

Has your sleeping pattern changed since this problem started? Yes [] No [] If so, how?

Has your energy or interest in your usual activities changed since this problem started? Yes [] No [] If so, how?

Have you seen a therapist about this problem? Yes [] No []
If yes, who: When:

Have you taken any medications for this problem? Yes [] No []
If yes, please list the medications that you recall. Did any of these medications cause especially bad side effects?

Did any of these medications help, at least somewhat?

What else have you tried to do to make this problem better?

To what extent does this problem interfere with your usual activities?

Are there other problems for which you are hoping to get help?

What do you hope will result from you getting help?

How will your life be different when you think you are better?

If your family is an important part of your recovery, what do they hope for you?

Related Past History

Have you had a similar problem in the past? Yes No

Have you had a different sort of mental or emotional problem in the past? Yes No

Have you ever been hospitalized for a psychiatric condition? Yes No
If yes, where? If yes, when?

In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed or lost all interest or pleasure in things that you usually cared about or enjoyed? Yes No

During the last six months, did you not work or participate in every day activities because of your mental health issues? Yes No

Has there been a time when you have had mood swings from very high to extreme lows? Yes No

Has there ever been a time when you have acted in a way that you or others have felt to be reckless, foolish, or risky? Yes No

Have you ever seen or heard things that others have not seen or heard? Yes No

Experience with alcohol and drugs

Do you use caffeine (coffee, tea, cola) on a daily basis? Yes No If yes, how much?

Do you use tobacco? Yes No If yes, how much?

Do you smoke marijuana? Yes No If yes, how often?

Do you drink alcoholic beverages? Yes No If yes, how often?

Was there ever a time when you were drinking more than was good for you? Yes No

Have you ever been arrested for DUII or DWI? Yes No If yes, how many times?

Has a doctor, counselor, or family member ever advised you to cut down or quite drinking? Yes No

Do you now or have you ever taken illicit drugs (street drugs)? Yes No If yes, what kind and when?

Was there ever a time when drug use interfered with the rest of your life in any way? Yes No
If yes when?

Have you felt you out to cut down on your drinking and drug use? Yes No

Have people annoyed you by criticizing your drinking and drug use? Yes No

Have you felt bad or guilty about your drinking and drug use? Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started? Yes No

Do you think you have a problem with your usage of alcohol, prescription medications, or illegal drugs?

Yes No

If you think you might have a problem, do you think about doing something about it? Yes No

If you have a problem with the use, abuse or dependence on alcohol, prescription medications or illegal drugs, are you actively working on staying clean and sober? Yes No

If you have used alcohol, prescription medications or illegal drugs in the past and are now clean and sober, what are you doing to support your sobriety?

Medical History

Who is your primary care physician (family doctor)?

When did you last see him or her?

If you see an alternative medical provide regularly (homeopath, chiropractor, naturopath, herbalist, etc.), who and for how long?

What do you do to take care of yourself?

Give an example of what you eat for meals?

Do you ever miss meals? Yes No If yes, why?

Have you ever had surgery? Yes No If yes, what kind and when

Have you had a serious medical problem in the past that is now resolved? Yes No If so, what?

Do you have any allergies – to medicines, food, or environmental? Yes No If so, what?

Are you presently taking any medications for problems other than your psychiatric condition? Be sure to include over the counter medications, herbal preparations or homeopathic remedies that you take regularly.

- | | <u>Name</u> | <u>Strength</u> | <u>Reason</u> |
|----|-------------|-----------------|---------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

At this time, do you have any of the following conditions?

High blood pressure	Yes 0	No 0	Premenstrual syndrome	Yes 0	No 0
Heart failure	Yes 0	No 0	Anemia	Yes 0	No 0
Mitral valve prolapse	Yes 0	No 0	Seizures	Yes 0	No 0
Diabetes	Yes 0	No 0	Head Injury	Yes 0	No 0
Cancer	Yes 0	No 0	Fainting or blackout spells	Yes 0	No 0
Asthma	Yes 0	No 0	Periods of lost memory	Yes 0	No 0
Emphysema	Yes 0	No 0			
Migraine Headaches	Yes 0	No 0			
Thyroid problem	Yes 0	No 0			
Ulcers	Yes 0	No 0			
Liver problem	Yes 0	No 0			
Arthritis	Yes 0	No 0			

Do you have any ongoing health problems not listed Yes No If so, what?

Have you noticed any recent changes in your general physical health? Yes No If so, what?

Have you done anything that puts you at increase risk for HIV (AIDS virus) infection? Yes No If so, what?

If you are female: What, if any, form of contraception are you using?

How many times have you been pregnant? How many babies have you delivered?

Were any of your pregnancies or post-partum periods complicated by significant psychological disturbance? Yes No

Personal and Family History

Where were you born? What was your childhood like?

Describe your parent's financial status? (Were you rich, poor, middle class, you don't know?)

Did you move around a lot while you were growing up? Yes No If yes, why?

What is the highest level of education you have completed?

Are you in school now? Yes No If yes, what is your goal?

Is there a particular ethnic group that your family or that you identify with?

If you belong to or regularly attend services of any organized religious faith, which one?

What did your family do for fun?

What is your occupation?

Are you working in a job that you trained for? Yes No If no, what are you trained to do?

Are you employed? Yes No If you are unemployed, how long have you been unemployed?

If you are retired, how long have you been retired? What did you do before you retired?

Are you living in a: House that you own House that you rent Apartment that you rent
 With family members With friends Homeless Other _____

Are you married? Yes No If you are married, spouse's occupation and place of employment?

Please list everyone who lives at the same house or apartment with you, their ages, and their relationship to you.

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Relationship</u>
1.			5.		
2.			6.		
3.			7.		
4.			8.		

If you have children that are not living with you, please give their names, ages, and city of residence.

Name Age City of residence

1.

2.

3.

If you have been previously married, how and when did your previous marriage(s) end?

Start Date End date

Have you ever served in the armed forces? Yes No If yes, when? Type of discharge?

Have you ever been arrested or been to court for any legal actions, either criminal or civil? (Include divorce and custody actions, but do not count minor traffic violations) Yes No

Please tell us about your family:

Biological father:

Current age or age at death?

Drinking problem or substance abuse? Yes No

Occupation?

Mental or emotional problems? Yes No

Describe current relationship with bio father:

Biological mother:

Current age or age at death?

Drinking problem or substance abuse? Yes No

Occupation?

Mental or emotional problems? Yes No

Describe current relationship with bio mother:

Foster, adoptive or stepfather (if any)

Current age or age at death?

Drinking problem or substance abuse? Yes No

Occupation?

Mental or emotional problems? Yes No

Foster, adoptive or stepmother (if any):

Current age or age at death?

Drinking problem or substance abuse? Yes No

Occupation?

Mental or emotional problems? Yes No

Please list the names and ages of your brothers and sisters:

Name

Age

1.

2.

3.

Have any of your relatives ever experienced:

Symptoms like yours? Yes No

Serious depression? Yes No

Attempted Suicide? Yes No

See a psychiatrist or counselor? Yes No

Abuse alcohol or drugs? Yes No

Are there any other physical or mental problems that "run in the family" that have not already been asked about? Yes No

Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month that you:

-have had nightmares about it or thought about it when you did not want to? Yes No

- tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

Yes No

- were constantly on guard, watchful, or easily startled? Yes No

- felt numb or detached from others, activities, or your surroundings? Yes No

How many close friends would you say you had?

What do you do for fun at this time?

Do you take vacations? What do you do?

Do you belong to any clubs, service clubs, or teams?

Name two dreams for your life that you have

1.

2.

Signature of Therapist

Date