ADULT INTAKE FORM

THE PSYCHOLOGY CLINIC, 2000 SOUTHWOOD DRIVE, LAKE CHARLES, LA 70605

DATE: _____

IDENTIFYING INFORMATION:

Client Name: _____
Address: _____
Date of Birth: _____
Email: _____
License Plate Number*: _____
(*Necessary for teletherapy services if needed)

Indicate your preferred means of communication:

		OK to leave a message: (circle)	
Cell Phone:	_____	YES	NO
Home Phone:	_____	YES	NO
Work Phone:	_____	YES	NO

May we contact you by Email if needed? YES NO

Emergency Contact Information:
In case of emergency, I give permission for the following party to be contacted:
Name: _____
Relationship: _____
Phone: _____

Does this person know you are coming to therapy? YES NO

PSYCHO-SOCIAL HISTORY

The following information is requested in order that your therapist may develop an initial understanding of the issues for which you are seeking counseling. It is okay to leave questions unanswered if you do not know an answer or are uncomfortable providing the information.

PRESENTING PROBLEM (reason you are seeking counseling):
Please provide a brief description of the problems you are experiencing:

_____
_____
_____
_____

How long have you been experiencing these problems? If possible, provide the approximate date/time- period during which you first began to have concerns about these issues: _____

PSYCHIATRIC/MENTAL HEALTH HISTORY

Have you received previous counseling for these or other concerns? YES NO
Approximate dates of treatment: _____

Have you ever received psychiatric out-patient treatment? YES NO
Approximate dates of treatment: _____

Have you ever been hospitalized for mental health issues? YES N0
Approximate dates of hospitalization/s: _____
_____

Is there a family history of psychiatric problems? YES NO
If you are able, please provide the relationship of family member/s and the diagnosis/es.
_____
_____
_____

Have you experienced any trauma (direct exposure /been a witness to actual or threatened death, serious injury, or sexual violence) recently or in the past? YES NO
If so, please provide a brief description and time frame of the event/s.

_____
_____
_____
_____
_____

Have you suffered any recent losses, emotionally distressing events, or changes in life circumstances? YES NO
If so, please provide a brief description and a time frame of the event/s.

_____
_____
_____
_____
_____

MEDICAL CONDITIONS/HISTORY:

Please list your current medical providers:
Primary Care Physician: _____
Psychiatrist: _____
Ob/Gyn: _____
Other Specialist/s: _____
_____

Please provide a brief explanation of any chronic medical conditions:
_____
_____
_____
_____
_____

Have you experienced any significant injuries or illnesses recently or in the past? If so, please provide a brief explanation.
_____
_____
_____
_____
_____

Please list current medications:

Medication	Dose	Prescribing Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SUBSTANCE USE:

Have you received substance abuse treatment previously? YES NO
If so, approximate dates?
_____

Do you drink alcohol? YES NO
Approximately how many drinks per week: _____

How many times in the last year have you had ***4 or more*** drinks at one time (if a woman) or ***5 or more*** drinks (if a man)?

Never Once-twice weekly More than twice weekly Once- twice monthly

More than twice monthly Once-twice a year More than twice a year

Do you use any non-prescribed drugs other than alcohol? YES NO

Has anyone ever suggested you may have a problem with alcohol/substance use?

YES NO

Is there a history of substance abuse in your family? YES NO

FAMILY HISTORY:

What best describes your upbringing:

_____ Raised by birth parents in an in-tact marriage.

_____ Raised by divorced birth parents

_____ Raised by divorced parents and stepparents.

_____ Raised by single parent

_____ Raised by widowed parent

_____ Adopted; raised in an in-tact marriage

_____ Adopted, raised by divorced parents

_____ Raised in foster care

_____ Raised primarily by another; relationship: _____

If parents were divorced, what age were you at time of divorce? _____

If parent/caregivers are deceased, please indicate date of death:

Mother _____ Father _____

Stepmother _____ Stepfather _____

Other: _____: *Relationship*: _____

How many full siblings do you have? _____

What is your birth order? _____

How many half/step siblings do you have? _____

How satisfied are you with the support you receive from your family?

Very unsatisfied Unsatisfied Satisfied Very satisfied

RELATIONSHIP HISTORY: (*please circle type of relationship***)**

Are you currently: Married In a committed partnership

Separated Divorced Widowed

(*please circle type of relationship):*

Date met current or most recent: partner spouse: _____

Date married/committed: partner spouse: _____

Date divorced / separated from: partner spouse: _____

Date widowed: _____

Are you currently experiencing difficulty with your relationship? YES NO

History of previous relationships:

Partner:	date committed	date separated
	_____	_____
	_____	_____
	_____	_____

Spouse:	date married	date divorced
	_____	_____
	_____	_____
	_____	_____

Please list ages and gender of your children; please indicate if step or adopted:

_____
_____
_____
_____
_____

Are there any other children in your household? YES NO
If so, please indicate relationship to you or your partner/spouse.

_____
_____
_____

SOCIAL HISTORY:
Are you active in any social/civic/religious organizations? YES NO

Are you able to enjoy leisure/recreational activities? YES NO
If no, why: _____
_____

How satisfied are you with the support you receive from friends?
Very unsatisfied Unsatisfied Satisfied Very satisfied

DEVELOPMENTAL HISTORY:
Provide a brief explanation of any significant developmental delays/learning difficulties in childhood:

_____
_____

Provide a brief explanation of any life situations which interfered with your education:

_____
_____
_____

EDUCATIONAL/OCCUPATIONAL HISTORY:
Highest level education: (Please circle)
High School: Attended Graduate
College: Attended Associates Bachelors Masters Doctorate

Current Employer: _____
Job Title: _____

LEGAL HISTORY:
Are you currently involved in any legal proceedings? YES NO

If so, please indicate the nature of the legal proceeding:

Family/divorce/custody: _____
Criminal: _____
Civil: _____

Do you have any previous convictions? YES NO

Please complete the symptom checklist on page 8.
Thank you for your time in completing this information packet. This information is kept strictly confidential.

CURRENT SYMPTOM CHECKLIST

Client Name: _____
Date: _____

Form completed by (if other than client): _____

Check the following symptoms/ behaviors you are currently experiencing ***(have been occurring in recent weeks or regularly for the past 2 to 3 months):***

Physical Symptoms

_____ Insomnia
_____ Nightmares
_____ Headaches
_____ Weight loss
_____ Too much sleep
_____ Too little sleep
_____ Loss of appetite
_____ Weight gain
_____ Low energy

Mood

_____ Angry
_____ Quarrelsome
_____ Depressed
_____ Tired
_____ Withdrawn
_____ Lonely
_____ Grief
_____ Feeling inferior
_____ Irritable
_____ Not enjoying things
_____ Lack of interest
_____ Detached
_____ Elevated/High mood
_____ Drastic & quick mood changes
_____ Lack motivation

Behavior

___ Shy
___ Impulsive
___ Lethargic
___ Have run away
___ Physically abusive
___ Verbally abusive/threatening
___ Problems with drugs/alcohol
___ Cheating/lying
___ Legal problems
___ Sexual problems
___ Unassertive
___ Blaming of others
___ Uncommunicative
___ Excessive energy
___ Compulsions
___ Being physically abused
___ Being verbally abused
___ Difficulty in relationships
___ Controlling/domineering
___ Demanding
___ Opposition to authority
___ Irresponsible
___ Lack self-control
___ Make inappropriate noises
___ Violent
___ Temper outburst
___ Failing at school
___ Behavior problems at school
___ Attention seeking
___ Sexual issues
___ Work difficulties
___ Dangerous behaviors
___ Damaged/stolen property of others
___ Overeating
___ Binging/purging
___ Gambling Excessively

Anxiety

___ Nervous
___ Stressed
___ Phobic
___ Worry a lot
___ Panic
___ Frustrated easily
___ Tense
___ Shaky/Jittery

Thought

___ Suicidal thoughts
___ Homicidal thoughts
___ Want to run away
___ Difficulty concentrating
___ Distractible & inattentive
___ Lack of trust
___ Feelings of unreality
___ Forgetful
___ Difficulty with memory
___ Lack self-esteem
___ Obsessive thoughts
___ Spiritual confusion
___ Racing Thoughts
___ Seeing/hearing things that aren't there