Adult Intake & History Form

Patient Name: ______________________________ Date of Birth: ________________ Age: ___________

Preferred Name (If Different): __________________ Religion: ____________________________________

Sex/Gender Identity: _________________________ Pronouns: ____________________________________

Race/Ethnicity: ____________________________ Sexual Orientation: ___________________________

Address: ____

How did you hear about us? ☐ Friend/Family ☐ Web Search ☐ Insurance ☐ Other: __________________

Referred by: ____

Concerns or problems for which you are seeking services: ____

____

FAMILY & RELATIONSHIPS

Your Relationship Status: ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ Single ☐ Widowed

Immediate Family Members

Name	Relationship	Age

Your Family of Origin (biological/adoptive parents, siblings, stepparents, etc.)

Name	Relationship	Age

Please describe how it was to **grow up** with your family of origin, including any problems.

____

____

Please describe your **current relationships** with family of origin members.

____

____

Current support network: ☐ Family of Origin ☐ Current Family/Household ☐ Romantic Partner/Spouse
☐ Friends ☐ Coworkers ☐ Online ☐ Religious Congregation ☐ Support Group ☐ Professionals

BIRTH & DEVELOPMENT

My Mother's Pregnancy With Me

Prenatal care? ☐ Y ☐ N

Alcohol or substance use during? ☐ Y ☐ N Type/Quantity? ____

Complications during pregnancy/birth: ____

Full Term ☐ Premature ☐ Adopted? ☐ Y ☐ N At what age? ___________________________________

My Developmental Milestones

Language/Speech: ☐ Typical ☐ Delayed/Atypical (how?) ____
Motor Skills: ☐ Typical ☐ Delayed/Atypical (how?) ____
Learning/Academic: ☐ Typical ☐ Delayed/Atypical (how?) ____
Daily Living Skills: ☐ Typical ☐ Delayed/Atypical (how?) ____

MEDICAL

My Medical History

Please indicate any **current and past** medical conditions and describe if applicable:

Head injuries ☐ Y ☐ N ____
Loss of consciousness ☐ Y ☐ N ____
Ear infections/tubes ☐ Y ☐ N ____
Visual impairments ☐ Y ☐ N ____
Sensory problems ☐ Y ☐ N ____
Neurological conditions ☐ Y ☐ N ____
Respiratory problems ☐ Y ☐ N ____
Heart conditions ☐ Y ☐ N ____
Diabetes ☐ Y ☐ N ____
Gastrointestinal conditions ☐ Y ☐ N ____
Autoimmune disorders ☐ Y ☐ N ____
Epilepsy or seizures ☐ Y ☐ N ____
Other conditions ☐ Y ☐ N ____
Surgeries and hospitalizations: ____

____

Current Medications	Dosage	Condition Treating

ACADEMICS

My Academic History

Current Student ☐ Y ☐ N School: ________________________ Major/Area of Study:______________________

Program Year (1st, 2nd, etc.): ________________________________ General Grades: ________________________

Current academic problems: ____

Highest degree completed: ☐ High School ☐ Vocational ☐ Bachelors ☐ Masters ☐ Doctorate/Professional

Academic problems: ☐ Behavior problems ☐ Attention problems ☐ Learning problems ☐ Repeated grades

Other Information:____

OCCUPATIONAL

My Occupational History

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled

Current Occupation (if applicable): ____

Position/roles: _________________________________ Length of employment: ____________________________

Previous Occupation/employer (if applicable): ____

Position/roles: _________________________________ Length of employment: ____________________________

Work Problems: ☐ Attendance ☐ Performance ☐ Relationships ☐ Dissatisfaction ☐ Quitting

Other Information:____

MENTAL HEALTH HISTORY

My Family's Mental Health History

Indicate known or suspected mental health problems experienced by biological relatives (past/current):

Depression	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Suicidal Ideation	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Suicide Attempts	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Completed Suicide	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Anxiety	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Panic Attacks	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Obsessions/Compulsions or Hoarding	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Bipolar Disorder/Mania/Hypomania	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Schizophrenia or Psychosis	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Abuse, Neglect, or Trauma	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Attention-Deficit/Hyperactivity Disorder (ADHD)	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Learning Disorders or Problems	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Autism	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Alcohol or Drug Abuse	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Incarceration or Arrests	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Personality Disorders	☐ Mother's side	☐ Father's side	☐ Sibling(s)
Other: ____	☐ Mother's side	☐ Father's side	☐ Sibling(s)

My Mental Health Diagnoses and History

Please let any **previous/current** mental health or psychiatric diagnoses you have received:

Diagnoses (ex: ADHD, depression)	When Diagnosed	Current Concern	Diagnosed by Whom
______________________________	____________________	☐ Y / ☐ N	_________________________
______________________________	____________________	☐ Y / ☐ N	_________________________
______________________________	____________________	☐ Y / ☐ N	_________________________
______________________________	____________________	☐ Y / ☐ N	_________________________
______________________________	____________________	☐ Y / ☐ N	_________________________

Indicate if child has a **history** of any of the following (even if not formally diagnosed):

- ☐ Depression
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Obsessive-Compulsive or Hoarding Disorders
- ☐ Bipolar Disorder
- ☐ Schizophrenia or Psychotic Disorders
- ☐ History of Abuse, Neglect, and/or Trauma
- ☐ Self-Harm (ex: cutting)
- ☐ Suicidality (Ideation and/or Attempts)
- ☐ Attention-Deficit/Hyperactivity Disorder (ADHD)
- ☐ Learning Disorders
- ☐ Autism Spectrum
- ☐ Alcohol or Drug Problems
- ☐ Incarceration or Arrests
- ☐ Personality Disorder Features
- ☐ Eating Disorders/Body Image Concerns

Other: ____

My Current Mental Health/Psychiatric Symptoms

Please check the box if **you are currently experiencing** any of the following:

- ☐ Abandonment Fears
- ☐ Aggression (Physical/Verbal)
- ☐ Alcohol or Drug Abuse
- ☐ Anger/Frustration/Irritability
- ☐ Anxiety/Worry
- ☐ Appetite Disturbance (too much/too little)
- ☐ Attention/Concentration Problems
- ☐ Body Image/Disordered eating
- ☐ Communication/Speech Problems
- ☐ Defiance/Rule-Breaking
- ☐ Depressed Mood/Sadness
- ☐ Discrimination/Minority Stress
- ☐ Eye Contact (Poor/Odd/Infrequent)
- ☐ Gender Identity/Sexual Orientation
- ☐ Hearing/Seeing Things (Hallucinations)
- ☐ Hyperactivity/Restlessness
- ☐ Impulsive/Risky Behaviors
- ☐ Insomnia/Sleep Problems
- ☐ Legal Problems
- ☐ Loss/Grief
- ☐ Lying
- ☐ Memory Impairment/Problems
- ☐ Mood Swings/Mania/Hypomania
- ☐ Obsessions/Compulsions
- ☐ Odd Beliefs/Delusions
- ☐ Poor Hygiene
- ☐ Relationship Problems
- ☐ Self-Harming Behavior
- ☐ Sexual Dysfunction
- ☐ Suicidality (Thoughts/Ideation)
- ☐ Sensory Sensitivities
- ☐ Thoughts of Hurting/Killing Others
- ☐ Trauma Symptoms
- ☐ Unexplained or Chronic Pain

My Abuse and Trauma History

Please any history of the following (including current/recent past):

- ☐ Natural Disaster
- ☐ Car Accident
- ☐ Fire or Explosion
- ☐ Physical Assault
- ☐ Sexual Assault
- ☐ Unwanted Sexual Contact
- ☐ Combat or Warzone Exposure
- ☐ Medical Trauma
- ☐ Robbery or Home Invasion
- ☐ Witnessed Trauma or Abuse of Someone Else
- ☐ Domestic Violence (Witnessed or Experienced)
- ☐ Childhood Physical Abuse
- ☐ Childhood Sexual Abuse
- ☐ Childhood Verbal Abuse
- ☐ Childhood Emotional Abuse
- ☐ Victim of Terrorism

Other: ____

My Substance Use History

Please list any substances/drugs you use (or used), including alcohol, nicotine, drugs, and prescription drugs

Substance	How Much	How Often	
______________________	______________	______________	☐ Current ☐ Past
______________________	______________	______________	☐ Current ☐ Past
______________________	______________	______________	☐ Current ☐ Past
______________________	______________	______________	☐ Current ☐ Past

Have you experienced any of the following as a result of your drug or alcohol use? (check all that apply)

- ☐ Arrests
- ☐ Blackouts
- ☐ Driving Under the Influence
- ☐ Employment Issues
- ☐ Family/Marital Conflict
- ☐ Feeling Guilty
- ☐ Fighting/Conflict
- ☐ Financial Problems
- ☐ Health Problems
- ☐ Increased Tolerance
- ☐ Seizures
- ☐ Unintentional Overdose
- ☐ Using More Than Intended
- ☐ Withdrawal Symptoms

Other: ____

My Legal History

Past and current legal problems:____

My Mental Health Treatment History

Current Psychiatrist: ___________________________ Current Therapist: ________________________________

Please list any **past outpatient** mental health services:

Provider	When	Why	Reason Ended/Stopped
____________________	___________	______________	___________________
____________________	___________	______________	___________________
____________________	___________	______________	___________________

Please indicate any past **testing/assessment** services (through school or independent clinician)?

Provider	When	Diagnoses Given

Please indicate if you will provide copies of past assessment report(s)? ☐ Y ☐ N

Indicate any **inpatient** mental health services received (inpatient hospitalizations, partial hospitalization programs (PHPs), residential treatment programs, and drug/alcohol treatment programs).

Where	When	Why	Outcome