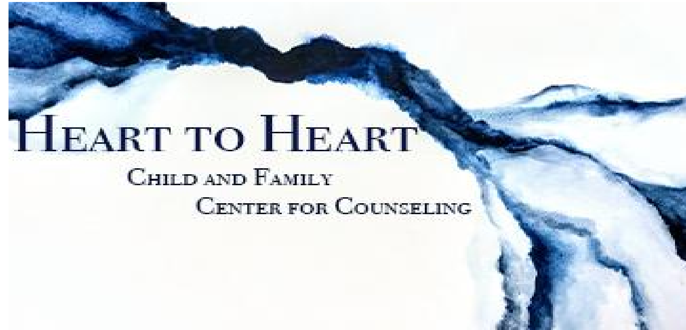

ADULT INTAKE

Click blank boxes to add text and click arrows on drop down boxes to select an answer.

Client Data:

Name: Birth Date: Age:

Gender:

Who referred you here?

Is English your preferred language?

If answered NO to this question, what is your preferred language?

Describe any needs related to your culture or faith that might help us with your therapy:

Place of Employment:

Contact Information:

Please understand we will use the address listed below for all communication we mail to your home, including billing statements. If you would like to make alternative arrangements with us regarding your mailing address, please do not hesitate to let your therapist know.

Address

City State Zip Code

Contact Methods Can we leave a message here?

Cell Phone			
Home Phone			
Work Phone			
Email Address			

HEALTH INSURANCE: Primary and Secondary Insurance Carrier:

Insurance Carrier (ex. BCBS):	
Is your primary insurance through MA or MHCP (Minnesota Healthcare Programs):	
Is your primary insurance through an employer?	
ID Number:	Group Number:
Name of Policy Holder:	
Address of Policy Holder:	
City, State, Zip of Policy Holder:	
Date of Birth of Policy Holder:	
Social Security Number of Policy Holder:	
Policy Holder’s Relationship to the Client (ex. self, spouse, parent):	
Insurance Carrier (ex. BCBS):	
Is your primary insurance through MA or MHCP (Minnesota Healthcare Programs):	
Is your primary insurance through an employer?	
ID Number:	Group Number:
Name of Policy Holder:	
Address of Policy Holder:	
City, State, Zip of Policy Holder:	
Date of Birth of Policy Holder:	
Social Security Number of Policy Holder:	
Policy Holder’s Relationship to the Client (ex. self, spouse, parent):	

Financial Guarantor (person responsible for payment)
The financial guarantor for an account is the person responsible for paying the bill. In most cases, this will be the client him/herself. If so, please fill in your own information. In other cases, someone else may be responsible. In that event, please fill in that person’s information and have him/her sign below.

Name of Guarantor:	Date of Birth:
Address of Guarantor:	
City, State, Zip of Guarantor:	

Guarantor's Relationship to the Client (ex. self, spouse, parent):

I understand I am solely responsible for any charges outstanding on the above client's account and accept responsibility for prompt payment of any outstanding balance.

Presenting Problem

Briefly describe your current difficulties:

What have you done to try and resolve your concerns? Who have you talked to about these concerns?

How long has this (these) problem(s) been a concern?

When was the problem first noticed?

By whom?

What seems to help the problem?

What seems to make the problem worse?

Have you received evaluation or treatment for the current problem or similar problems?

If so, when and with whom?

Please describe any stressors that may be affecting you today (divorce, relationship changes, unemployment, school, peers, losses, etc.). Note any changes in your mood or behaviors:

How are these concerns affecting you and your family?

Please describe your strengths:

Additional Concerns not covered:

Family & Social History

Marital status of parents:

If your parents were separated or divorced, what age were you at the time of separation?

Your current Marital status:

List all people living in your current household:

Name	Age

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

Have you had previous psychotherapy?

with (previous therapist’s name)

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

If yes, please list:

Prescribed by:

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician?

If yes, who is it?

Are you currently seeing more than one medical health specialist?

If yes, please list:

When was your last physical?

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

Are you currently on medication to manage a physical health concern? If yes, please list:

Are you having any problems with your sleep habits?

If yes, check where applicable:

Sleeping too little   Sleeping too much   Poor quality sleep

Disturbing dreams   Other

How many times per week do you exercise?

Approximately how long each time?

Are you having any difficulty with appetite or eating habits?

If yes, check where applicable: Eating less   Eating more   Binging   Restricting

Have you experienced significant weight change in the last 2 months?

Do you regularly use alcohol?

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

How often do you engage recreational drug use?

Do you smoke cigarettes or use other tobacco products?

Have you had suicidal thoughts recently?

Have you had them in the past?

Are you currently in a romantic relationship?

If yes, how long have you been in this relationship?

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship?

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

Have you ever experienced any of the following?

Extreme depressed mood	
Dramatic mood swings	
Rapid speech	
Extreme anxiety	
Panic attacks	
Phobias	
Sleep disturbances	
Hallucinations	
Unexplained losses of time	
Unexplained memory lapses	
Alcohol/substance abuse	
Frequent body complaints	
Eating disorder	
Body image problems	
Repetitive thoughts (e.g. obsessions)	
Repetitive behaviors (e.g. frequent checking, hand washing	
Homicidal thoughts	
Suicidal attempts	If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed?

If yes, who is your currently employer/position?

If yes, are you happy with your current position?

Please list any work-related stressors, if any:

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious?

If yes, what is your faith?

If no, do you consider yourself to be spiritual?

Do you want your therapist to pray with you?

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty		**Family member**
Depression		
Bipolar disorder		
Anxiety disorder		
Panic attacks		
Schizophrenia		
Alcohol/substance abuse		
Eating disorders		
Learning disabilities		
Trauma history		
Suicide attempts		

OTHER INFORMATION

What do you like most about yourself?

What are effective coping strategies that you have learned?

What are your goals for therapy?

ACE Questionnaire:

Question 1: Before your 18th birthday, did a parent or other adult in the household often or very often… swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?
Yes: No:

Question 2: Before your 18th birthday, did a parent or other adult in the household often or very often… push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?
Yes: No:

Question 3: Before your 18th birthday, did an adult or person at least five years older than you ever… touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?
Yes: No:

Question 4: Before your eighteenth birthday, did you often or very often feel that… no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?
Yes: No:

Question 5: Before your 18th birthday, did you often or very often feel that… you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes: No:

Question 6: Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reason?
Yes: No:

Question 7: Before your 18th birthday, was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes: No:

Question 8: Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
Yes: No:

Question 9: Before your 18th birthday, was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes: No:

Question 10: Before your 18th birthday, did a household member go to prison?
Yes: No:

Total of questions answered "Yes:"

THANK YOU FOR FILLING THIS OUT!

This confidential information is provided in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.