



**The Care and
Counseling
Center**
Adult Intake Form

Name: _____

Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

Please check all of the behaviors and symptoms that you consider problematic:

- | | | |
|--|---|---|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Suspicion/paranoia |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Wide mood swings |
| <input type="checkbox"/> Poor memory/confusion | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Seasonal mood changes | <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Loss of pleasure/interest | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Aggression/fights | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Self-harm behaviors | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Parenting problems |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Low self worth | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Guilt/shame | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Visual hallucinations | <input type="checkbox"/> Recurring, disturbing memories |
| <input type="checkbox"/> Other: _____ | | |

Are your problems affecting any of the following?

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Health | |

Yes No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe: _____

Yes No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

Yes No Have you recently been physically hurt or threatened by someone else? If yes, please describe: _____

Yes No Have you gambled in the past 6 months? If yes, let us know the following
 Yes No Have you ever felt the need to bet more and more money?
 Yes No Have you ever had to lie to people important to you about how much you gambled?

Therapist Notes:

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health Problems	Who?
Mother				Hyperactivity	
Father				Sexually Abused	
Stepmother				Depression	
Stepfather				Manic Depression	
Siblings				Suicide	
				Anxiety	
				Panic Attacks	
				Obsessive-Compulsive	
Spouse/partner				Anger/Abusive	
Children				Schizophrenia	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	

- Parents legally married or living together Mother remarried: Number of times _____
 Parents temporarily separated Father remarried: Number of times _____
 Parents divorced or permanently separated

Please check if you have experienced any of the following types of trauma or loss:

- | | | |
|---|--|---|
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Neglect | <input type="checkbox"/> Lived in a foster home |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Multiple family moves |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Crime victim | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Parent substance abuse | <input type="checkbox"/> Parent illness | <input type="checkbox"/> Loss of a loved one |
| <input type="checkbox"/> Teen pregnancy | <input type="checkbox"/> Placed a child for adoption | <input type="checkbox"/> Financial problems |

Therapist Notes:
Init: _____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Therapist Notes:
Init: _____

Name: _____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

Yes No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

Yes No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

Therapist Notes:
Init: _____

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

- | | | | |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Surgery | <input type="checkbox"/> Serious accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Other: _____ |

Please list any CURRENT health concerns: _____

Current prescription medications: None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: None
If yes, please list: _____

Therapist Notes:
Init: _____

