Adult Intake Form

Please bring any supporting documents (such as your medical records, records of prior psychological treatments, psychological testing or school reports) to the first session. All responses are confidential. No information about you or your family will be released without your prior written consent. Thank you in advance for taking the time to provide this important information.

Name: _________________________________ Age: _____Sex: ___ Date: ______
Birthdate: __/___/____

Significant other/ Married to:
First name: _____________________ Time together: ________________

Children/step children:
Name Age

____
____
____

Others living in same house (relationship/age):

____
____

Reason(s) for referral/coming to see me:

____
____

Has this problem been treated before: Yes ___ No ___
If yes, what treatment modalities (i.e. individual, family therapy), including medications, have been tried:____
____

Name: Dates of Treatment Phone Number:

____
____
____

Name(s) current/past mental health professionals:____
____

Current functioning:

Recent stressors: (i.e. death in family, move to new location, new medical illness):

____
____

Vocation/Profession: _____________________________
Place of employment: ___________________________________

Work related stressors: ____

Leisure activities you enjoy:

____
____

Please check any of the symptoms/problems below that apply.
Difficulty with sleeping (falling asleep/staying asleep)________
Eating/appetite ________ Excessive concerns about weight ________
Loss of interest in activities ________
Thinking about one topic excessively ________ Doing one activity over and over ________
Thinking about a traumatic event where you or a loved one could have been killed________
Loss of energy/frequent fatigue ________ Difficulty with fears/phobias ________
Thoughts of death/dying ________ Unusual thoughts or behavior ________
Tics or recurrent involuntary movements ________
Seeing or hearing things that others cannot see (or hear)________
Excessive social awkwardness or Difficulty finding/keeping friendships________
Feeling easily irritated ________ Excessive conflicts with family ________
Excessively suspicious/fearful ________ Excessive conflicts with friends ________
Trouble with gambling ________ Need to be perfect - "perfectionist" ____ ____
Trouble with sexual behavior(s) ________ Difficulty with gender/sexual orientation ________
Problems with legal system/law ________ Difficulty being alone ________
Excessive/impulsive spending ________ Substance abuse ________
Frequently anxious/tearful ________ Caffeine Usage________
"Panic attacks" ________ Cigarettes ________
Anxiety with public speaking ________ Alcohol Usage ________
Easily distracted from tasks ________ Marijuana ________
Difficulty with sustained attention ________ Stimulants (cocaine, methamphetamine) _______
Other ____________________________ ____ ____

Past Mental Health History:

Have you ever been hospitalized for psychiatric reasons?
If yes, please list name of hospital, dates and phone number(s)
Name: ________________________________ Date: _____________
Number:____
____

Have you ever been treated with psychotropic medications in the past? Yes ___ No __
If yes, please list names, dosages, and length of treatment:
____
____
____ Was the medication effective?_______________
What side effects did you experience from the medication?_____________________________

Suicide attempt(s)? Yes__ No__

History of hurting yourself (i.e. cutting, burning, etc.) without intent to kill self? Yes__ No__

If you are currently thinking about killing yourself before you can make it to your first appointment please, call 911 and/or let a loved one know; please get the help that you deserve before it is too late.

(If more space is needed please continue on back of page)

Past Medical History

Any current medical problems?

If yes, please list medical problems, year diagnosed, medications you are taking for the problem and your primary physician who is treating medical condition:

____
____
____
____
____
____
____ _____________
____

History of head trauma, loss or consciousness, seizures, or serious medical illnesses?
If yes, please briefly describe event(s) and treatments given:

____
____
____
____

Please check if you have the following current (or recurrent) medical complaints:

___ Headaches
___ Fever
___ Numbness/weakness
___ Dizziness when standing up suddenly
___ Slurred speech
___ Memory loss
___ Visual problems
___ Hearing problems
___ Chest pain
___ Abdominal pain
___ Difficulty walking
___ Recurrent cough
___ Tremors/dizziness
___ Joint Pain
___ Shortness of breath
___ Difficulty urinating
___ Difficulty defecating
___ Excessive fatigue
___ Food intolerance
___ Diarrhea/constipation
___ Allergies
___ Frequent falls, injuries
___ Rashes
___ Bothersome itchy skin
___ Other skin problems: ________________
___ Other aches/pains: If yes, please specify location(s) ______________________________
___ Other symptoms: ____

If you are female, what is you menstrual history:

Age of menarche __________________ Date of last menstrual period: _________________
Cyclic mood symptoms: Yes ___ No____
Irregular/painful or heavy menses: __________________________________

Family History:

Is there a family history (among biological relatives) of the following:
clinical depression, anxiety, or unusual thoughts or
behaviors?____

Have any of your relatives received treatment with psychiatric medications?_____________

If yes, please indicate disorder(s) and outcome of medication trials: i.e. effective, stopped due to side effects, etc.____

Is there a family history of uncommon or rare medical disorders? Yes ___ No ___
Did any biological relatives die due to medical (or unknown) causes at a relatively young age? Yes ___ No __

Your Developmental History: (please check if yes)
____ Difficulties during pregnancy
____ Possibility of exposure to alcohol/drugs in utero
____ Difficulties during delivery
____ Feeding difficulties
____ Very sensitive to touch/sounds
____ Excessive difficulty with separation
____ Excessive temper tantrums
____ Difficulties/delays with walking
____ Difficulties/delay in talking
____ Difficulty calming down (self soothing) when upset
____ Any history of serious falls or loss of consciousness

Please fax the completed form to (301) 434-4751 or bring it with you to your first appointment.

Thank you.