Adult Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Personal Information:

Name: .....

Date Of Birth: .....

Sex: .....

Age: .....

Marital Status: .....

Home Address: .....

Nationality: .....

Religion: .....

Occupation: .....

Diagnosis: .....

Name Of Psychiatrist: .....

Treatment History:

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no.

Have you had previous psychotherapy? ( ) no ( ) yes, with
(previous therapist's name).....

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
( ) yes ( ) no.

If yes, please list:

.....

Prescribed by:

.....

Health & Social Information:

Do you currently have a primary doctor? ( ) yes ( ) no.

If yes, please list their names:

.....

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list their names:

.....

When was your last physical:

.....

How would you rate your current physical health (please circle one)?

Poor Unsatisfactory Satisfactory Good Very Good

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

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.....

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

.....

.....

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

.....

.....

Are you having any problems with your sleep habits? ( ) yes ( ) no

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?

.....

What type of exercise due you participate in ?

.....

Approximately how long each time?

.....

Are you having any difficulty with appetite or eating habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) yes ( ) no

Do you regularly use alcohol? ( ) no ( ) yes

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?
( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Are you currently in a romantic relationship? ( ) no ( ) yes

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	( ) yes ( ) no
• Dramatic mood swings	( ) yes ( ) no
• Rapid speech	( ) yes ( ) no
• Extreme anxiety	( ) yes ( ) no
• Panic attacks	( ) yes ( ) no
• Phobias	( ) yes ( ) no
• Sleep disturbances	( ) yes ( ) no
• Hallucinations	( ) yes ( ) no
• Unexplained losses of time	( ) yes ( ) no
• Unexplained memory lapses	( ) yes ( ) no
• Alcohol/substance abuse	( ) yes ( ) no
• Frequent body complaints	( ) yes ( ) no
• Eating disorder	( ) yes ( ) no
• Body image problems	( ) yes ( ) no
• Repetitive thoughts (e.g. obsessions)	( ) yes ( ) no
• Repetitive behaviors (e.g. frequent checking, hand washing)	( ) yes ( ) no
• Homicidal thoughts	( ) yes ( ) no
• Suicidal attempts	( ) yes ( ) no, if yes then when?

.....

Eductional History

Please indicate the year you started and the year completed your academic years.

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Which Nursery school did you attend?

.....

Which Primary School did you attend?

.....

Which High School did you attend?

.....

Which University or College did you attend?

.....

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) yes ( ) no

If yes, who is your currently employer/position?

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If yes, are you happy with your current position?

.....

Please list any work-related stressors, if any

.....

.....

Family 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	Yes/ No	Family Member
• Depression	( ) yes ( ) no	.....
• Bipolar disorder	( ) yes ( ) no	.....
• Anxiety disorder	( ) yes ( ) no	.....
• Panic attacks	( ) yes ( ) no	.....
• Schizophrenia	( ) yes ( ) no	.....
• Alcohol/substance abuse	( ) yes ( ) no	.....
• Eating disorders	( ) yes ( ) no	.....
• Learning disabilities	( ) yes ( ) no	.....
• Trauma history	( ) yes ( ) no	.....
• Suicide attempts	( ) yes ( ) no	.....
• Chronic illness	( ) yes ( ) no	.....

Family Relationship History

Please describe the relationship you have with your father ?

.....

.....

Please describe the relationship you have with your mother?

.....

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If you have any siblings please describe the relationship you have with them?

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OTHER INFORMATION

What do you consider to be your strengths?

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What do you like most about yourself ?

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.....

What are effective coping strategies that you have learned?

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.....

What are your goals for therapy?

.....

.....

Forensic History

Have you ever spent time in jail?

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