Intake Form – Adult

Please respond to all questions to the best of your ability; this questionnaire is long, but thorough answers will ***significantly*** reduce the amount of time needed for your intake appointment. If you are completing this form on behalf of someone else, please answer all questions in reference to that person.

Patient's legal name:	Patient's biological sex (e.g., male/female):
Patient's preferred name:	Patient's pronouns (e.g., he/his):
Patient's DOB:	Patient's race/ethnicity:
Today's date:	Your name (if completed by another person):

Presenting Problem or Concern:

1. Please briefly describe your concern(s) and what you are hoping to gain from this evaluation:

2. Have you been treated for this problem before? If yes, please describe how (e.g., medication, therapy, etc.):

3. Are there any recent stressors in your life (e.g., lost job, death in family, new baby, etc.)?

Medical History:

1. To your knowledge, what were the conditions of your birth/early development (select all that apply):

☐ Normal, no problems	☐ Stay in the NICU
☐ Born prematurely; how early? _____	☐ Delayed milestones (e.g., walking, talking, toilet training)
☐ Complications with delivery	☐ Other: _____

2. Which of the following medical conditions do you have or have you had in the past (select all that apply)?

☐ High blood pressure	☐ High cholesterol
☐ Diabetes/elevated glucose	☐ Hypo (low) thyroid
☐ Cardiac problems/heart attack	☐ Hyper (high) thyroid
☐ Asthma	☐ GERD/Acid reflux
☐ Stroke	☐ Epilepsy/seizures
☐ Headache/migraines	☐ Head injury/concussion
☐ Covid-19 infection	☐ Other: _____

3. Please list any surgeries or major hospitalizations/illnesses you have had in your life:

4. Have you received any Covid-19 vaccinations? If yes, how many?

5. Please list all medications and dosages:

6. How much sleep do you typically get in a 24-hour period?

7. Do you have any of the following problems with sleep (check all that apply)?

☐ Sleep too little	☐ Sleep too much
☐ Trouble falling asleep/insomnia	☐ Trouble staying asleep
☐ Poor quality sleep	☐ Nightmares/disturbing dreams
☐ Heavy snoring/stop breathing	☐ Other: _____

8. Have there been any recent changes to your weight or appetite? If yes, please describe:

9. Do you exercise regularly? If yes, please describe typical exercise plan (e.g., once per week, daily, etc.):

10. Do you regularly consume alcohol? If yes, how many drinks do you have in a typical week?

11. Do you regularly use tobacco products? If yes, please describe your typical use (e.g., one pack of cigarettes per day, one can of dip per day, vape pen, etc.):

12. Do you/have you used any recreational drugs? If yes, please describe what drugs and how often (e.g., marijuana daily, experimented with cocaine once, etc.):

Psychiatric History:

1. Are you currently receiving counseling/psychotherapy or have you received these services in the past? If yes, please list the therapist's name and practice:

2. Have you ever been given any formal diagnoses related to your mental health (select all that apply)?

☐ ADD/ADHD	☐ Post-traumatic Stress Disorder (PTSD)
☐ Generalized Anxiety Disorder	☐ Obsessive-Compulsive Disorder (OCD)
☐ Major Depressive Disorder	☐ Schizophrenia
☐ Bipolar Disorder	☐ Other: _____

3. If one or more are selected above, please specify when this was diagnosed and by whom:

4. Are you currently taking prescribed medication for your mood/behavior (e.g., antidepressants)? If yes, please list medication names and dosages:

5. Have you ever experienced any of the following (select all that apply)?

☐ Extreme depressed mood	☐ Wild mood swings
☐ Extreme anxiety	☐ Rapid speech
☐ Panic attacks	☐ Nightmares/sleep disturbance
☐ Hallucinations	☐ Delusional beliefs
☐ Alcohol/substance abuse	☐ Eating Disorder
☐ Suicidal thoughts/attempts	☐ Homicidal thoughts/attempts

6. Have you ever had to be psychiatrically hospitalized? If yes, please describe when or for what reason:

7. Has anyone in your family (immediate family or relatives) experienced any of the following?

☐ ADD/ADHD	☐ Post-traumatic Stress Disorder (PTSD)
☐ Generalized Anxiety Disorder	☐ Obsessive-Compulsive Disorder (OCD)
☐ Major Depressive Disorder	☐ Schizophrenia
☐ Bipolar Disorder	☐ Other: _____

Developmental/Social History:

1. Where were you born and raised?

2. Who raised you (e.g., biological parents, adoptive parents, grandparents)? If your parents divorced, please describe when and who you lived with afterward?

3. How many siblings do you have? Are they older or younger?

4. How would you describe your childhood (including family relationships, traumatic events, childhood abuse, your personality, etc.)?

5. What is your current marital status?

☐ Married; how long? _____
☐ Divorced; how many times? _____
☐ Single
☐ Engaged/Long-term relationship

6. Do you have any children? If yes, please list their ages:

7. Who all lives in your home currently?

Educational/Occupational History:

1. Is English your first/primary language? If no, please list first language(s) and when you learned English:

2. What is the highest level of education completed?

☐ Less than high school graduate; what is the highest grade completed? _____	☐ High school diploma
☐ GED	☐ Some college; no degree
☐ Associate's degree; what field? _____	☐ Bachelor's degree; what field? _____
☐ Master's degree; what field? _____	☐ Doctoral degree (PhD, PsyD, JD, etc.)

3. Which of the following describes your academic experience in grade school (select all that apply and add notes as applicable)?

☐ Normal, no problems
☐ Gifted classes/skipped a grade (what grade?) _____
☐ Special classes for learning disability (what was the disability?) _____
☐ Had to repeat a grade (what grade?) _____
☐ Tutoring outside of school (for what subject?) _____
☐ Other: _____

4. Which of the following describes your social experience in grade school (select all that apply)?

☐ Enjoyed school	☐ Disliked school
☐ Had many friends	☐ Had a few friends
☐ Had no friends/were bullied	☐ Rarely got into trouble
☐ Had to be disciplined frequently (e.g., detention, suspension, etc.)	☐ Other: _____

5. Have you ever served in the military? If yes, what branch, rank, occupation, etc.?

6. What is your current employment status?

☐ Employed full-time	☐ Employed part-time
☐ Receiving SSDI/other method of income	☐ Student
☐ Unemployed	☐ Stay-at-home parent/caregiver

7. If you are employed, who is your current employer/what is your job?

8. What other types of work have you done in the past (e.g., retail, fast food service, customer service, etc.)?

Other Information:

If there is anything else you'd like to add or explain further, please do so here: