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Intake Form

The information on this form is private and completely confidential, so please answer the following questions honestly and with as much detail as possible so that I can personalize your treatment and help you as quickly and efficiently as possible.

Name _____ Age/D.O.B. _____ Today's Date _____

Presenting Problem

Chief complaint _____
_____
Duration and severity of symptoms _____
Precipitating events (what brought you into treatment)_____
_____
Current Stressors _____
_____

Physical Health

Any physical problems past or present (describe and explain)_____
_____

Psychiatric History

Prior diagnosis/medication/treatment for mental illness? List and explain_____
_____
Prior therapy? With whom? Duration? Reason for termination? _____
_____
Hospitalizations for mental illness or substance abuse? List and explain_____
_____
Current Medications_____
_____
Any family members with history of mental illness or addiction?_____
_____
Any family members currently taking medications for mental illness?_____
_____

Substance Abuse/use history (see addendum at end of this form)

Family History

Your place of birth_____
Age of parents at time of birth_____
Were you or any siblings adopted? If yes, please explain_____
Names and ages of siblings_____
_____
Describe past and present relationships with siblings_____
_____
_____
Use several adjectives to describe your mother_____
_____
Use several adjectives to describe your father_____
_____
Describe your relationship between you and you're your mother and father (past and/or current)_____
_____
_____
Describe the relationship between your mother and father_____

_____

_____

Any history of physical, sexual, emotional abuse? If yes, please explain_____

_____

How many years in your childhood home? Did you move often? If yes, explain_____

_____

Did anyone in your family die?_____If yes, please answer the following_____

Name	Relationship to you	age at death	date of death	cause of death

_____

_____

_____

School History

Did you go to pre-school/camp/daycare prior to kindergarten? _____ Separate easily?_____

_____

Kindergarten experience: positive/negative?_____

_____

Elementary school years experience: positive / negative?_____

_____

Middle School years experience: positive/negative? _____

_____

High School years experience: positive/negative? Sexual experiences? _____

_____

Did you graduate?_____GED? _____College?_____If yes, where and when? Positive/negative? Grades?

_____

_____

Graduate college? _____Major? _____Minor? _____Post College Schooling? _____

Any diagnosed learning disabilities or social problems? _____

Please explain how this effected you?_____

Any specific dating or sexuality issues during school age years? If yes, please explain_____

_____

_____

Interpersonal Relationships

Do you have a best friend?_____Several good friends?_____Many acquaintances?_____

Some friends but no-one close?_____No friends?_____

_____

When you are upset, who do you go to for support?_____

Is that usually helpful?_____ why or why not?_____

How long does it usually take to feel better when you are with this person/people? Explain_____

_____

Dating / Marital History

Age when you first dated_____First Kiss? _____First sexual experience?_____

Were these experiences positive or negative? _____

Are you currently (circle one) single married widowed dating someone living with someone_____

Age when youyou're your current partner?_____How long have you been together?_____

Describe your current relationship?_____

_____

Any previous marriages? _____Why did it end?_____

_____

Do you have any children from current or prior relationships? Explain:--_____

_____

Describe your relationship your children_____

Employment History

Current occupation _____Where are you working and for how long? _____

Are you satisfied with your current job or career? If no, please explain_____

Longest time at one job?_____ if unemployed, where were you last employed and for how long?_____

Legal History

Past convictions?_____ any pending litigation?_____ any DWI/DUI or other driving violations?_____

Any family members ever convicted of a crime?_____ any other legal issues?_____

Impulse Control / Anger Management

What do you usually do when you get angry or upset?_____

Do you carry a weapon or have access to weapons?_____

Have you ever harmed yourself in any way (including thoughts of suicide or previous attempts?_____

Military History

Have you ever been in the military? _____Branch/Rank_____ Active Combat?_____

Incarcerated while in the military?_____ Type of discharge: _____

Therapy Goals

What type of therapist are you looking for? _____

Have you ever had a bad therapy experience?_____

Has this made it difficult to come back?_____

How are you looking to change?_____ How long do you expect it to take to reach your goals?_____

Are your therapy goals realistic?_____

Anything else important that you feel I should know?_____

ADDENDUM: **SUBSTANCE USE HISTORY**

1. What do you consider your drug of choice? Check all that apply.

None Amphetamines Alcohol Benzodiazepines Cocaine Crack Hallucinogens Heroin Inhalants Marijuana, Hashish, THC Methamphetamines Non-Prescriptive Methadone Other Opiates and Synthetics Over-the-Counter PCP Tranquilizers Other

2. Have you used tobacco regularly in last 30 days? Check if yes
3. How many cigarettes do you smoke daily? _____ At what age did you begin using? _____
4. Have you ever quit smoking? Check if yes If yes, for how long? _____
5. Indicate your experience with the following substances:

Substance:		Age of 1st Use	Date of Last use	Current Amount	Current Frequency	Past Use Amount/Frequency
Alcohol: beer, wine, hard liquor	Never Yes					
Tobacco: chewing, smoking or smokeless	Never Yes					
Marijuana (pot, weed, trees, hash)	Never Yes					
Benzodiazepines: Valium, Xanax, Librium, Ativan, Klonopin	Never Yes					
Barbiturates: Phenobarbital, Seconal	Never Yes					
Amphetamines: Ritalin	Never Yes					
Cocaine/crack: ice	Never Yes					
Hallucinogens: acid, LSD, mushrooms	Never Yes					
Robitussin/Antihistamines (Tylenol pm)	Never Yes					
Opiates/Narcotics: (OxyContin, Codeine, Vicodin, Heroin, Morphine, Methadone)	Never Yes					
Inhalants (cleaning supplies, white out, whippets, etc.)	Never Yes					
Club/Predatory Drug: Ecstasy Ketamine, Rohypnol, GHB	Never Yes					
Other Drugs – name: _____	Never Yes					

6. What substance has caused you problems? _____
Explain (what type of problems/when/currently?)_____
_____

7. Kind of alcohol consumed/ average amount consumed:

Wine _____ Avg. amount: _____
Hard liquor _____ Avg. amount: _____
Beer _____ Avg. amount: _____
Combination _____ Avg. amount: _____

8. Usual type of drinking:

☐ Always with others ☐ Usually with others ☐ Sometimes with others ☐ With others and alone equally

☐ Sometimes alone ☐ Usually alone ☐ Always alone

9. Where do you drink? ☐ Home ☐ Parties ☐ Bar Name of bar: _____

10. How much money do you typically spend per week on alcohol and/or drugs? _____

11. When is the last time you went 3+ days without drinking or drugging? _____

12. Life time substance use treatment? ☐ Inpatient How many times? _____ ☐ Outpatient How many times? _____

13. What is the longest period you have been alcohol-free? _____

14. What is the longest period you have been drug-free? _____

15. What is the longest period you have been abstinent from both alcohol & drugs? _____

Check if overdosed? Check if ever used drugs intravenously Check if ever had alcohol or drug related seizures

16. Have you ever had shaky hands, night sweats, diarrhea or have been unable to sleep when you have tried to stop or cut down on alcohol or drugs? Check if yes When: _____

17. Have you ever attended a 12 Step Program such as AA or NA? _____ No _____ Yes

If yes, was it helpful or not helpful? _____

If not helpful, reasons: _____

18. Has anyone ever expressed concern about your drinking or drug use?_____
_____

19. Has someone else's drinking or other drug use affected you past or present? _____
_____