# ADULT PSYCHOTHERAPY INTAKE

***The information in this packet is confidential and protected under the privacy act of 1974.***

Date: ______________________________

## I. Demographics:

Name (First, Middle Initial, Last):______________________________

Name of parent/guardian (if under the age of 18 years old):______________________________

Gender: ☐ Male ☐ Female Birth Date: ____________________ Age: __________

Address (Street Number and Street Name):______________________________

City:______________________________ State:________ Zip: __________

Phone number: (_____)________________ Type: ☐ Work ☐ Home ☐ Cell May we leave a message? ☐ Yes ☐ No

Alternate phone number: (_____)____________ Type: ☐ Work ☐ Home ☐ Cell May we leave a message? ☐ Yes ☐ No

Email Address: ______________________________ May we email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential means of communication.*

How were you referred to us?______________________________

What issues/concerns brought you to therapy? ______________________________

______________________________

______________________________

## II. Race / Ethnic Ancestry:

☐ Asian ☐ Black ☐ Caucasian / White ☐ Hispanic / Latino(a)
☐ Native American / Alaskan ☐ Pacific Islander ☐ Other ______________________________

## III. Marital/Family History:

Check all that apply to you currently:
☐ Never Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed
☐ Dating ☐ Married ☐ Common Law ☐ Domestic partnership

How long have you been in a committed relationship (married, common law, domestic partnership)? ____________________

How is your relationship with your spouse / partner? ______________________________

How many times have you been married? ______________________________

Do you have any children? ☐ Yes ☐ No If yes, what are their ages and genders?________________________________________

________________________________________________________________________________

How is your relationship with your children?______________________________________________

## IV. Social History:

Who raised you? Indicate one or more of the following:

☐ Biological parents ☐ Adoptive parents ☐ Relatives ☐ Step-parents ☐ Grandparents ☐ Others

Overall, how would you describe your childhood? Check all that apply:

☐ Happy ☐ Uneventful ☐ Unhappy ☐ Hard to remember ☐ Frightening

☐ Other: ________________________________________________________________

Indicate if you experienced or witnessed any of the following types of abuse/assault at any time, including your childhood:

☐ Physical ☐ Sexual ☐ Verbal ☐ Psychological / Emotional

## V. Education:

What is your highest level of education?

☐ Obtained GED ☐ High school graduate ☐ Partial college ☐ Associates college degree

☐ College graduate ☐ Graduate degree in progress ☐ Graduate degree: ______________________________

How would you describe your academic performance?

☐ Excellent (As/ Bs) ☐ Good (Bs) ☐ High average (Bs/Cs) ☐ Average (Cs) ☐ Poor (Cs/Ds/Fs)

Check all that applied to you during your schooling:

☐ No problems ☐ Difficulty concentrating ☐ Difficulty with teachers/staff

☐ Academic problems ☐ Behavioral problems ☐ Learning disabilities

## VI. Legal History:

Have you ever been in jail/prison? ☐ Yes ☐ No

Are you currently on probation or parole, or awaiting a pending court case? ☐ Yes ☐ No

Prior and current charges/arrests (please list reasons and provide dates): ______________________________

________________________________________________________________________________

## VII. Employment History:

Are you currently employed? ☐ Yes ☐ No

If yes, describe your job: ______________________________________________________

Do you enjoy your work? ☐ Yes ☐ No

What is stressful about your current job?__________________________________________

Check all that applied during your employment. I had problems with:

☐ No problems ☐ With supervisors ☐ Difficulty following rules

☐ With coworkers ☐ With customers ☐ Difficulty controlling temper

## VIII. Leisure/Social Functioning

Which of these do you enjoy doing in your free time?

☐ Playing sports ☐ Reading ☐ Going to bars or clubs ☐ Playing video games ☐ Shopping
☐ Motorcycles/Racing ☐ Talking with friends ☐ Exercising ☐ ____________________

Are you currently engaging in these leisure activities? ☐ Yes ☐ No

## IX. Substance Use History

Do you drink alcohol? ☐ Yes ☐ No

What did you drink (e.g., beer, liquor, mixed drinks, etc.)? ____________________

On average, how **much** did you drink at one time (e.g., number of glasses, shots, 12 oz bottles, etc.)? ____________________

On average, how **often** did you drink alcohol (e.g., daily, weekly, times/week or month)? ____________________

Do you use tobacco products? ☐ Yes ☐ No If yes, what type? ____________________

How much do you use (per day)? ____________________

Do you use caffeine products (e.g., soda, coffee, tea, caffeine, pills, chocolate)? ☐ Yes ☐ No

If yes, what type? ____________________

How much do you drink/take per day? ____________________

Have you ever used illicit / illegal drugs or misused prescription medications? ☐ Yes ☐ No

Do you currently use illicit / illegal drugs or misuse prescription medications? ☐ Yes ☐ No

What type(s) of drugs do you use? ____________________

What is the approximate date of your last use of illicit drugs? ____________________

Are you concerned about your current drinking or drug use? ☐ Yes ☐ No

Have you ever received substance abuse treatment (including treatment at a military base)? ☐ Yes ☐ No

If so, please list where you received treatment, and when this occurred: ____________________

____________________

## X. Mental Health History:

Have you ever had outpatient treatment or therapy? ☐ Yes ☐ No

When were you treated, and by whom: ____________________

What was the diagnosis? ____________________

Have you ever been hospitalized in a psychiatric unit or psychiatric hospital? ☐ Yes ☐ No

When and where: ____________________

Have you ever experienced a head injury or traumatic brain injury? ☐ Yes ☐ No Describe: ____________________

____________________

Are you currently taking psychiatric medications? ☐ Yes ☐ No

| Name of Medication | Reason | Dose |
|---|---|---|
| | | |
| | | |
| | | |

Does anyone in your family have mental illness or an emotional difficulty? ☐ Yes ☐ No

Please specify: ______________________________

Have you ever intentionally harmed yourself without suicidal intent (e.g. cutting, burning, etc.)? ☐ Yes ☐ No

If yes, when was the last time? ______________________________

Are you feeling helpless or hopeless? ☐ Yes ☐ No

Do you have CURRENT thoughts of suicide or self-harm? ☐ Yes ☐ No

Do you have a specific plan or intent to hurt yourself currently? ☐ Yes ☐ No

Have you ever had suicidal thoughts or attempted suicide? ☐ Yes ☐ No

If yes, please list the date this occurred, and describe the circumstances: ______________________________

______________________________

Do you have CURRENT thoughts about homicide or hurting someone else? ☐ Yes ☐ No

If yes, do you have a specific plan or intent to harm someone else? ☐ Yes ☐ No

## XI. Medical History:

Current medical problems, surgeries, or illnesses and date of onset:

______________________________

______________________________

Do you have chronic pain? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

If yes, how many times per week: ______________________________

If yes, what type of exercise do you do? ______________________________

Do you follow any specific dietary practices (e.g., diet programs, gluten free, etc.)? ☐ Yes ☐ No

If yes, please describe: ______________________________

Do you have any allergies (e.g., food, animals, seasonal, etc.)? ☐ Yes ☐ No

If yes, please describe: ______________________________

## XII. Current Symptoms / Problems:

Check all that have applied to you in **the past 2 weeks**:

| | |
|---|---|
| ☐ Depressed mood | ☐ Difficulty falling asleep |
| ☐ Loss of interest in activities | ☐ Difficulty staying asleep |
| ☐ Feelings of guilt | ☐ Unable to return to sleep |
| ☐ Low energy, tiredness | ☐ Decreased interest in sex |
| ☐ Poor concentration | ☐ Increased interest in sex |
| ☐ Changes in appetite | ☐ Grief/sense of loss |

Check all that have applied to you in **the past 2 weeks**:

| | |
|---|---|
| ☐ Excessive worry | ☐ Anxiety in social or performance situations |
| ☐ Anxiety (general) | ☐ Uncontrollable impulses |
| ☐ Panic or anxiety attacks | ☐ Repetitive Behaviors |
| # of panic attacks per week: ___________ | ☐ Repeated rituals (such as checking locks many times) |

Check all that have applied to you in **the past 30 days**:

| | |
|---|---|
| ☐ Rapid mood swings | ☐ Risky behaviors |
| ☐ Irritability | ☐ Decreased need for sleep / staying awake for several days |
| ☐ Frequent anger outbursts | ☐ Unusual increase in energy / activity |
| ☐ Racing thoughts | ☐ Extreme behaviors (such as spending or promiscuity) |
| ☐ Increased self-esteem | |

Check all that have applied to you in **the past 30 days**:

| | |
|---|---|
| ☐ Extreme calorie restriction / counting | ☐ Weighing yourself daily |
| ☐ Self-induced vomiting | ☐ Troubles eating or swallowing |
| ☐ Using laxatives to control weight | ☐ Fear of gaining weight |

Check all that have applied to you in **the past 30 days**:

| | |
|---|---|
| ☐ Suspiciousness | ☐ Seeing people, animals, or things that others cannot see or say are not there |
| ☐ Feeling as if people are following you or watching you | ☐ Hearing voices or noises that others cannot hear or say are not there |
| ☐ Paranoid thoughts | |

Check all that have applied to you in **the past 30 days**:

| | |
|---|---|
| ☐ Memory problems | ☐ Problems with remembering or finding words |
| ☐ Problems with speech or speaking | |

## XIII. Personal Strengths:

Please check any of the following characteristics that you consider to be your strengths:

| | | | |
|---|---|---|---|
| ☐ Empathy | ☐ Creativity | ☐ Curiosity | ☐ Open-mindedness |
| ☐ Integrity | ☐ Vitality | ☐ Love | ☐ Kindness |
| ☐ Leadership | ☐ Forgiveness / mercy | ☐ Humility / modesty | ☐ Prudence |
| ☐ Gratitude | ☐ Hope | ☐ Humor | ☐ Spirituality |
| ☐ Love of learning | ☐ Perspective / wisdom | ☐ Bravery | ☐ Persistence |
| ☐ Social intelligence | ☐ Socially responsible / teamwork | ☐ Fairness | |
| ☐ Self-regulation / self-control | ☐ Appreciation of excellence / beauty | | |

## XIV. Support / Spirituality:

Do you have any spirituality concerns? ☐ Yes ☐ No

Please check any of the following you consider to be a source of support:

| | | | |
|---|---|---|---|
| ☐ Spouse / Partner | ☐ Nuclear / Immediate Family | ☐ Extended Family | ☐ Close Friend |
| ☐ Group of Friends | ☐ Church / Synagogue / Mosque / Temple | ☐ 12-Step Program | ☐ Service System |

**IF YOU HAVE NEVER SERVED IN THE MILITARY SERVICE, STOP HERE**

**Current and prior military, please complete the next section.**

## XV. Military Service

Indicate the component(s) and service branch(es) that applied to you (check all that apply):

☐ Active Duty ☐ National Guard ☐ Reserves

☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy

Initial Enlistment / Commission date: ________________ Final Discharge date: ______________ Total Time in Service: ______

Type of Discharge:

☐ Retired (Time in Service or Medical) ☐ Honorable Discharge ☐ Medical Discharge

☐ Other than Honorable ☐ Dishonorable Discharge ☐ Administrative Discharge

Rank at Discharge: _________________________ Highest Rank:_______________________

Job / Duty Title: ____________________________ Duties:_

Check all that apply to you with regard to your performance during your military duties:

☐ No problems ☐ Physical outbursts ☐ Negative counseling(s)

☐ Problems with Chain of Command ☐ Verbal disagreements ☐ Administrative action

☐ Difficulty following rules ☐ Difficulty controlling temper ☐ Problems with others in unit

Did you receive any of the following? [ ] Court Martial [ ] Article(s) 15 [ ] UCMJ [ ] Other: ____________________

If so, please provide the date of disciplinary action, and briefly describe the circumstances:_____________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Please provide date(s) of deployment(s), duration of tour (e.g., 12 months), and location below:

| Start Date | End Date | Duration | Location |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

Did you receive incoming fire from small arms, mortars, or bombs? ☐ Yes ☐ No

**<u>DURING</u> your military service**, did you experience anything that continues to cause nightmares / intrusive thoughts? ☐ Yes ☐ No

Was this event a sexual assault? ☐ Yes ☐ No

**BRIEFLY** describe any traumatic event(s) that happened to you during your military service that still bother(s) you:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

During the event(s):

- Were you physically injured? ☐ Yes ☐ No
- Was someone else physically injured? ☐ Yes ☐ No
- Did you think your life was in danger? ☐ Yes ☐ No
- Did you think that someone else's life was in danger? ☐ Yes ☐ No

How did you respond emotionally DURING or AFTER the disturbing event(s)? Please circle all that apply.

| Horror | Excited | Terror | Confused | Helpless | Shame |
|---|---|---|---|---|---|
| Fear | Sadness | Grief | Guilt | Other feelings: ______________________ | |

# Thank you for completing this questionnaire

# Please complete any additional measures or turn in your paperwork to the front desk if complete.