ADULT CLINICAL INTAKE

Today's Date:_____

Name_____ D.O.B._____
Age:_____ Preferred Name/Nickname:_____

Address:_____

Emergency Contact Information:
Name:_____ Relationship_____ Phone_____

Occupation: _____ Employer**:**_____

Who referred you? _____

When you have completed therapy, what would you like to be different in your life?
_____

_____ **Goals**

What skills would you like to build?

☐ Stress management ☐ Communication skills
☐ Anxiety management ☐ Conflict resolution
☐ Setting boundaries with others ☐ Being able to say no
☐ Build self-esteem ☐ Build confidence in skills and abilities
☐ Create more balance in life ☐ Build parenting strategies
☐ Develop better partnering skills ☐ Skills to manage depression
☐ Better understand your emotions ☐ Improved emotional regulation
☐ Anger management ☐ Healing from past traumas
☐ Improve sleep
☐ Other_____

CURRENT SYMPTOM CHECKLIST

Instructions: Over the past two weeks, how often have you been bothered by any of the following symptoms?

0=Not at all 1=Several days 2=More than half the days 3=Nearly everyday

Little interest or pleasure in doing things_____
Feeling down, depressed, or hopeless_____
Trouble falling asleep, staying asleep and/or sleeping too much_____
Feeling tired or having little energy _____
Poor appetite or overeating _____
Feeling bad about yourself, that you are a failure or have let yourself or your family down_____
Trouble concentrating on things, such as reading the newspaper or watching TV_____
Moving or speaking so slowly that other people have noticed, or being so fidgety or restless that you have been moving around more than usual_____
Thoughts that you would be better off dead or hurting yourself in some way_____

***Instructions*:** Over the **past two weeks**, how often have you been bothered by any of the following symptoms?

0=Not at all 1=Several days 2=More than half the days 3=Nearly everyday

Feeling nervous, anxious or on edge_____ Not being able to stop or control worrying_____
Worrying too much about different things_____ Trouble relaxing_____
Being so restless that it's hard to sit still_____ Becoming easily annoyed or irritable_____
Feeling afraid as if something awful might happen_____

Place a mark next to the following symptoms that have occurred ***in the past 6 months:***

Group A

☐ having a plan for how to end your life
☐ feelings of hopelessness
☐ severe mood swings
☐ lack of personal hygiene or grooming
☐ lack of motivation
☐ social isolation or withdrawal
☐ low self-esteem
☐ being unusually irritable
☐ difficulty stopping tears
☐ feelings of excessive/inappropriate guilt
☐ self-injurious or harmful behavior (cutting, scratching, burning)

Group B

☐ periods of ***abnormally and persistently*** elevated, high or irritable mood
☐ periods of ***abnormally and persistently*** increased energy or focus on a task
☐ significant periods of overblown self-esteem
☐ significant periods of feeling grandiose; (feeling like you could do anything)
☐ periods of decreased need for sleep ***without feeling tired***
☐ more talkative than usual or pressure to keep talking
☐ racing thoughts
☐ easily distracted by unimportant things
☐ ***extreme*** focus on "getting things done" at school, work, or home.
☐ excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling)

Group C

☐ being easily fatigued
☐ muscle tension
☐ irritability as a result of worry
☐ sleep disturbance

Group D

☐ panic attacks; how often? _____

Symptoms associated with panic attacks: (check all that apply)

☐ feelings of choking
☐ nausea or abdominal upset
☐ numbness or tingling sensations
☐ fear of losing control or "going crazy"
☐ chest pain or discomfort
☐ hot or cold flashes
☐ feeling "unreal" or detached from self
☐ fear of dying
☐ having to go with others in order to feel comfortable

Group E

☐ considerable fear or anxiety about situations in which you may be judged (e.g., having a conversation, meeting new people)
☐ fear of being observed (e.g. eating or drinking)

☐ fear of performing in front of others
☐ experiencing persistent, excessive phobia (e.g. heights, closed spaces, specific animals, etc.)
Please list phobias_____
☐ recurrent and bothersome thoughts, ideas, or images that are unwanted and cause anxiety
☐ you have tried to ignore the thoughts or stop them with some other action
☐ repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating) that must be done or you feel anxious
☐ needing to have things done a certain way or you become very upset
☐ the obsessions are time-consuming
☐ recurrent skin picking, resulting in sores
☐ recurrent pulling out of one's own hair, eyelashes, or eyebrows, resulting in hair loss

Group F
☐ experienced, witnessed, or learned of an actual or threatened death, serious injury, or sexual violence
Traumatic event:_____
☐ recurrent and upsetting thoughts of the trauma
☐ recurrent distressing dreams related to the trauma
☐ flashbacks in which it feels like the trauma is recurring
☐ intense or ongoing psychological distress to events that resemble the trauma
☐ intense physical symptoms of panic or fear to events that resemble the trauma
☐ spending effort avoiding thoughts or feelings associated with a past trauma
☐ persistent avoidance of people, places, or activities that cause you to remember the trauma
☐ inability to recall an important aspect of the trauma
☐ persistent negative beliefs (e.g. "I am bad," "No one can be trusted," "The world is not safe")
☐ distorted thoughts about why the trauma happened causing you to blame yourself or others
☐ constantly negative emotional state (e.g. fear, anger, guilt)
☐ marked decreased interest in important activities
☐ feeling detached or distant from others
☐ feeling numb or restricted in your feelings
☐ feeling that your future is shortened
☐ quick startle response
☐ feeling like you are always watching for bad things to happen

Group G
☐ trouble sustaining attention or being easily distracted
☐ lacking attention to detail
☐ restless, fidgety
☐ makes decisions impulsively
☐ trouble maintaining an organized work or living area
☐ difficulty completing projects
☐ feeling overwhelmed by the tasks of everyday living
☐ impatient, easily frustrated
☐ frequent traffic violations or near accidents
☐ inconsistent work performance
☐ procrastination
☐ making comments to others without considering their impact
☐ difficulty delaying what you want; having to have your needs met immediately

Group H
☐ restriction of food intake that leads to a less-than-normal body
☐ intense fear of gaining weight or becoming fat even though at a significantly low weight

☐ engaging in persistent behaviors that interfere with weight gain
☐ persistent over-concern with body shape and weight
☐ lack of recognition of the seriousness of the current low body weight
☐ recurrent episodes of binge eating large amounts of food
☐ eating, in a certain time frame, definitely larger amounts of food than most people would eat in the same time ☐ a sense of lack of control over eating during the episode
☐ recurrent activities such as self-induced vomiting and/or the misuse of laxatives, water pills, strict dieting or excessive exercise

Group I

☐ finding it hard to understand what others are thinking or feeling
☐ getting very anxious about social situations
☐ finding it hard to make friends or preferring to be on your own
☐ seeming blunt, rude, or not interested in others without meaning to
☐ finding it hard to say how you feel
☐ taking things very literally-for example, you may not understand sarcasm or phrases like "break a leg"
☐ having the same routine every day and getting very anxious if it changes
☐ not understanding social "rules", such as not talking over people
☐ avoiding eye contact
☐ getting too close to other people, or getting very upset if someone touches or gets too close to you
☐ noticing small details, patterns, smells, or sounds that others do not
☐ having a very strong interest in certain subjects or activities
☐ liking to plan things carefully before doing them

Group J

☐ seeing things that are not real
☐ hearing sounds or voices that are not real
☐ peculiar behaviors
☐ marked lack of initiative
☐ delusional or bizarre thoughts (thoughts you know others would think are false)
☐ seeing objects, shadows, or movements that are not real
☐ periods of time where your thoughts or speech are not connected or do not make sense to you or others
☐ severely impaired ability to function at home or at work
☐ inappropriate mood for the situation (i.e. laughing at sad events)
☐ frequent feelings that someone or something is out to hurt you or discredit you
☐ periods of extreme irritability, physical or verbal aggression, or rage

FAMILY HISTORY

Who primarily raised you?

☐ both biological parents
☐ adoptive parents
☐ biological mother and stepfather
☐ biological father and stepmother
☐ biological mother
☐ biological father
☐ paternal grandparents
☐ maternal grandparents
☐ other: _____

Parent's current marital status:
☐ married to each other
☐ never married or together
☐ parents divorced when you were _____years old
☐ mother deceased for ____years (*age of client* at mother's death_____)
☐ father deceased for ____years (*age of client* at father's death_____)

Family Members:
number of brothers _____ sisters _____
birth order of client: _____ of _____ siblings
number of step brothers_____ sisters_____
number of half- brothers_____ sisters_____
deceased family
members_____

How would you describe your childhood?
☐ Happy ☐ Frightening ☐ Unhappy ☐ Dull
☐ Hard to remember ☐ Secure ☐ Regimented ☐ Sad
☐ Painful ☐ Delightful ☐ Problematic ☐ Normal

Did you witness abuse as a child?
☐ No ☐ Yes ☐ Emotional ☐ Verbal ☐ Physical ☐ Sexual
If yes, by whom:_____

Did you experience abuse as a child?
☐ No ☐ Yes ☐ Emotional ☐ Verbal ☐ Physical ☐ Sexual
If yes, by whom:_____

Mother/father/siblings have experienced the following problems:
*alcohol/drug abuse***:** ☐ mother ☐ father ☐ siblings(s) ☐ grandparent(s)
significant depression: ☐ mother ☐ father ☐ siblings ☐ grandparent(s)
significant anxiety: ☐ mother ☐ father ☐ siblings ☐ grandparents(s) *other known mental illness in the family:*_____
suicide attempt: ☐ mother ☐ father ☐ siblings ☐ grandparents(s)
completed suicide: ☐ mother ☐ father ☐ siblings ☐ grandparents(s)
anger problems: ☐ mother ☐ father ☐ siblings ☐ grandparents(s)
jail/prison: ☐ mother ☐ father ☐ siblings ☐ grandparents(s)

Please list your biological, step, and adopted children:

Name	Age	Living w/you	Name	Age	Living w/you
_____	____	☐ Y ☐ N	_____	____	☐ Y ☐ N
_____	____	☐ Y ☐ N	_____	____	☐ Y ☐ N
_____	_____	☐ Y ☐ N	_____	____	☐ Y ☐ N

Are there any other persons living in your home? ☐ Yes ☐ No
If yes, whom?_____

Relationships

Marital Status: (check all that apply)

☐ not currently in a relationship
☐ currently in a relationship (for how long?_____)
☐ engaged (for how long?_____)
☐ married (for how long?_____)
☐ divorced(for how long?_____)
☐ separated (for how long?_____)
☐ divorce in process (for how long?_____)
☐ live-in partner (for how long?_____)
☐ widowed (for how long?_____)
☐ prior marriages (self)
☐ prior marriages(partner)

On a scale of 1-10 how would you rate your satisfaction with your relationship?_____

How would you describe your partner? (Check all that apply)

☐ Warm
☐ Understanding
☐ Argumentative
☐ Uncaring
☐ Perfect
☐ Indifferent
☐ Distant
☐ Unpleasant
☐ Tense
☐ Affectionate
☐ Judgmental
☐ Happy
☐ Boring
☐ Unhappy
☐ Unforgiving
☐ Engaging
☐ Abusive
☐ Enjoyable

Relationship concerns (if any):

☐ past affairs
☐ current affairs
☐ trust issues
☐ finances
☐ lack of time together
☐ verbal abuse
☐ physical abuse
☐ substance abuse
☐ poor communication

Sexual Identity/Gender Identity:

☐ heterosexual ☐ cisgender ☐ gay ☐ lesbian ☐ bisexual
☐ questioning ☐ pansexual ☐ asexual ☐ non-binary (preferred prefix____)
☐ transgender (preferred prefix:_____) ☐ transitioning ☐ post-transition
☐ experiencing gender dysphoria

Sexual Health:
On a scale of 1-10 how would you rate your sexual satisfaction? _____

Do you have any concerns that <u>you</u> may be addicted to pornography or have a sex addiction? ☐ No ☐ Yes

Do you have any concerns that your <u>partner</u> may be addicted to pornography or have a sex addiction?
☐ No ☐ Yes

Sexual Health Issues:
During foreplay, intercourse, or partnered sexual stimulation, do you experience any of the following? (please check all that apply):

☐ lack of arousal
☐ difficulty achieving orgasm
☐ vaginal dryness
☐ lack of genital sensation (tingling/warmth/excitement)
☐ loss of orgasm intensity (muffledor short in duration)
☐ erectile difficulty

☐ decreased sense of connection with partner
☐ lack of focus on/awareness of sexual feelings
☐ difficulty with sexual response (quick, slow, or intermittent)
☐ genital pain -If so, please describe_____
☐ lack of desire

SOCIO-ECONOMIC/CULTURAL HISTORY

Living situation: (check all that apply)

☐ housing adequate
☐ homeless
☐ dependent on others for housing
☐ housing is overcrowded
☐ housing is dangerous/deteriorating

Financial situation:

☐ no current financial problems
☐ impulsive spending
☐ large indebtedness
☐ relationship conflicts over finances
☐ poverty or below poverty level

Social support system:

☐ supportive network
☐ substance use-based friends
☐ distant from family of origin
☐ a few friends
☐ no friends

Employment:

☐ employed and satisfied
☐ employed but dissatisfied
☐ unemployed
☐ supervisor conflicts
☐ unstable work history
☐ coworker conflicts

Education (Check all that apply):

☐ Graduated High School
☐ GED
☐ Attended some college (number of years_____)
☐ Graduated College: Diploma/Degree(s) Earned:_____
☐ Learning difficulties: if checked please specify:_____

Cultural Identity:

Please indicate the nationality or ethnicity that you identify with: _____

Have you ever served in the military? ☐ Yes ☐ No

If yes, what were the terms of your discharge?

☐ Still on active duty
☐ Honorable discharge
☐ Honorable discharge (mental health)
☐ Dishonorable discharge
☐ Honorable discharge (physical health)
☐ Does not apply

Legal:

☐ no current legal problems
☐ now on parole/probation
☐ arrest(s) **<u>were</u> <u>not</u>** substance-related
☐ arrest(s) substance-related

Describe last legal difficulty_____

☐ this treatment is court ordered
☐ jail/prison_____ (number of times)/Total time served ____months/___years

Spiritual:
What, if any, is your religious preference?_____
Are your spiritual beliefs an important part of your life**?** ☐ Yes ☐ No

Substance Use

On the average, how often do you drink alcohol?
☐ Never ☐ Once or twice a year ☐ Daily ☐ Once a week
☐ Once a month ☐ Several times a week

On average, when you drink, how much do you drink? ☐ 1-3 drinks ☐ 4-8 drinks ☐ 8 or more

Do you currently have a medical card for the use of marijuana? ☐ No ☐ Yes

Do you currently use CBD in any form? ☐ No ☐ Yes If yes, what form do you use it and how often:

_____

Do you currently use Delta 8? ☐ No ☐ Yes If yes, how often: _____

In the last year, have you experienced any of the following?

Picked up or charged with a drug-related driving offense?	☐ Yes ☐ No
Lost time from school or work because of use?	☐ Yes ☐ No
Experienced a medical problem because of use?	☐ Yes ☐ No
Been fired from a job because of use and its effects?	☐ Yes ☐ No
Felt you ought to cut down on your drinking or drug use?	☐ Yes ☐ No
Do people annoy you by criticizing your drinking or drug use?	☐ Yes ☐ No
Felt bad or guilty about your drinking or drug use?	☐ Yes ☐ No
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes ☐ No

Which of the following substances have you ever used?

☐ None	☐ Heroin	☐ Mushrooms
☐ Cocaine	☐ Marijuana	☐ Acid
☐ Bath salts	☐ PCP (Angel Dust)	☐ Pain pills w/o a prescription
☐ Crack	☐ Crank	☐ Ecstasy/Molly
☐ LSD	☐ Methamphetamine	☐ Inhalants
☐ Opium	☐ Tranquilizers	☐ K2/Spice

Have any of the above substances been used <u>in the last 12 months</u>? ☐ No ☐ Yes
If yes, which substances: _____

Substance use status:

☐ no history of abuse	☐ early partial remission
☐ active abuse	☐ sustained full remission
☐ early full remission	☐ sustained partial remission

Treatment history:
☐ O*utpatient*: Month/Year_____
Facility:_____
City/State_____

☐ I*npatient:* Month/Year_____
Facility:_____
City/State_____

☐ 12-step program ☐ stopped on your own

Have you ever received a DUI or DWI? ☐ No ☐ Yes /When_____

Do you smoke cigarettes? ☐ No, never have ☐ No, I quit ☐ Yes/How many per day?_____

Do you use a vape or e-cig? ☐ No, never have ☐ No, I quit ☐ Yes/How many day?_____

How many caffeinated beverages do you consume daily, on average?
☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Mental Health

Are you currently under the care of a psychiatrist? ☐ No ☐ Yes
If yes, Name: _____Clinic:_____

Have you previously been involved in counseling? ☐ Individual ☐ Marital ☐ Family
If yes, Name:_____Clinic:_____
Are you willing to sign a release of information for records? ☐ No ☐ Yes

Have you ever been hospitalized for mental health issues or suicidal thoughts?
☐ No ☐ Yes/When:_____

Strengths

How would you describe your strengths?

☐ Smart
☐ Funny
☐ Caring
☐ Resourceful
☐ Good work ethic
☐ Well-balanced
☐ Organized
☐ Wise
☐ Enthusiastic
☐ Passionate
☐ Helpful
☐ Multi-tasker
☐ Positive
☐ Good listener
☐ Calm under pressure
☐ Good communicator

Physical Health

Are you currently under the care of a doctor or other health practitioner? ☐ No ☐ Yes
If yes, Name: _____ Clinic:_____

Describe your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Health Issues:_____
_____

Have you had any major illnesses or hospitalizations recently? ☐ No ☐ Yes
If yes, Explain:_____

Current Medications (if any):
Medication_____Dose:_____
Medication_____Dose:_____
Medication_____Dose:_____
Medication_____Dose:_____

How many hours of sleep do you get on average? _____hours ☐ delayed sleep ☐ early waking

Do you exercise regularly? ☐ No ☐ Yes ☐ Try to

Do you have any known allergies? ☐ No ☐ Yes If yes, please describe:_____
_____