# Adult (18+) Intake Form

Name: _____Date of Birth: _____
Current address: _____
Preferred phone number(s): _____
Is it okay to leave a voicemail at this number? YES NO
Is it okay to send text message to this number? YES NO
Preferred email: _____
Is it okay to correspond via email? YES NO
Emergency contact number: _____
Relationship to emergency contact: _____

Please give a brief description of why you are seeking treatment:

_____
_____
_____
_____
_____

Describe any known family history of mental health or substance abuse issues (please include grandparents, aunts, uncles, siblings, parents, etc.)

_____
_____
_____
_____

## Previous Mental Health History

| Provider/Agency name and address: | Reason for treatment: | Length of treatment: |
|---|---|---|
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## Academic History

What is the highest grade you have completed? _____
Have you ever been diagnosed with any intellectual/cognitive disabilities? YES NO

## Employment

Are you currently employed? YES NO
What is your professional title? _____

## Medical History

| Name of Primary Care Doctor: | Address of provider: | Phone #:<br><br>Fax #: |
|---|---|---|
| Name of Psychiatrist (if applicable): | Address of provider: | Phone #:<br><br>Fax #: |

List any known allergies (medication or otherwise):

_____

_____

List any medical issues (current or past) as well as any medications prescribed (including dosages):

_____

_____

_____

List any history of drug/alcohol abuse (including specific substances and approximate date of use):

_____

_____

_____

Over the past 90 days, have you experienced any of the following:

- ☐ Trouble sleeping and/or nightmares
- ☐ Eating more or less than usual
- ☐ Sleeping more or less than usual
- ☐ Fatigue/lack of energy
- ☐ Loss of interest or pleasure in formerly enjoyable activities
- ☐ Difficulty focusing
- ☐ Change in sex drive
- ☐ Flashbacks of traumatic events
- ☐ Suicidal or homicidal thoughts
- ☐ Excessive worry or anxiety
- ☐ Avoiding specific events, places, objects or people
- ☐ Racing thoughts
- ☐ Pressured speech
- ☐ Irritability/Anger outbursts
- ☐ Mood swings
- ☐ Difficulty with interpersonal relationships at home, at work, or in the community
- ☐ Challenges related to impulsivity (i.e. participating in risky behaviors without considering their consequences)

Signature: _____ Date: _____