ITGW
5818 B Hubbard Drive
Rockville, Maryland 20852
(301) 468-4849
www.GreaterWashingtonTherapy.com

ADULT INTAKE FORM

Client's name:____ Date____

Gender: ______ F ______ M

Date of birth: ____________________________ Age: ___________________

Form completed by (if someone other than client): ____

Address: ____ Apartment Number: ___________

City: ____ State: ________________ Zip: _________________

Phone (Home): _____________________ (Cell): _____________________ (Work): _____________________

ext: ________

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs ___ ADHD

___ Relationship Difficulties ___ Trauma ___ Stress ___ Educational Evaluation

___ Educational Difficulties ___ Other mental health concerns (specify): ____

____

MARITAL STATUS

____ Single
Length of time: _________

____ Divorce in process
Length of time: _________

____ Unmarried, living together
Length of time: _________

____ Legally married

____ Separated

____ Divorced

Length of time: _________ Length of time: _________ Length of time: _________

____ Widowed ____ Annulment

Length of time: _________ Length of time: _________ ____ Total number of marriages

Assessment of current relationship (if applicable): __________ Good __________ Fair __________ Poor

FAMILY INFORMATION

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Significant others (e.g., brother, sisters, grandparents, step relatives, half relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No

Assessment of current relationships with family: __________ Good __________ Fair __________ Poor

PARENTAL INFORMATION

____ Parents legally married ____ Mother remarried: Number of times: ________

____ Parents have ever been separated ____ Father remarried: Number of times: ________

____ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): ____

____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? ________ Yes _______ No

If Yes, please describe: ____

____

Has there been history of child abuse? ____ Yes ____ No If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): ________________________

____

Comments re: childhood development: ____

SOCIAL RELATIONSHIPS

Assessment of current social relationships: __________ Good __________ Fair __________ Poor

Comments: ____

How would you described yourself in social relationships: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower ____ Friendly

____ Loyal ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive ____ Needy

____ Other (specify): ____

Sexual orientation: _________________ Comments: ____

Sexual dysfunctions? ____ Yes ____ No If Yes, describe: _____________________________________

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? ____________________________________

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No If Yes, describe: ______________

____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not at all ____ Little ____ Moderate ____ Extremely

Are you affiliated with a spiritual or religious group? ____ Yes ____ No If Yes, describe: ____________________________

Were you raised within a spiritual or religious group? ____ Yes ____ No If Yes, describe: ____________________________

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe: ____

LEGAL

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: ______________________________

____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: ____

PAST HISTORY

Traffic violations: ____ Yes ____ No

Criminal involvement: ____ Yes ____ No

DWI, DUI, etc.: ____ Yes ____ No

Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

EDUCATION

Fill in all that apply: Years of education: _____________ Currently enrolled in school? ______ Yes______ No

____ High school graduate ____ GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: ______________________________

____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: ______________________________

____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: ______________________________

Other training: ____

Special circumstances (e.g., learning disabilities, gifted): ____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired ____ Social Security ____ Student ____ Other (describe): ____________________

MILITARY

Military experience? ____ Yes ____ No Combat experience? ____ Yes ____ No Where: ____________________

Branch: ____________________ Discharge date: ____________________

Type of discharge: ____________________

Date enlisted: ____________________ Rank at discharge: ____________________

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity How often now? How often in the past?

Activity	How often now?	How often in the past?

MEDICAL/PHYSICAL HEALTH

____ AIDS
____ Alcoholism
____ Abdominal pain
____ Abortion
____ Allergies
____ Anemia
____ Appendicitis
____ Arthritis
____ Asthma

____ Dizziness
____ Drug abuse
____ Epilepsy
____ Ear infections
____ Eating problems
____ Fainting
____ Fatigue
____ Frequent urination
____ Headaches

____ Nose bleeds
____ Pneumonia
____ Rheumatic fever
____ Sexually transmitted diseases
____ Sleeping disorders
____ Sore throat
____ Scarlet fever
____ Sinusitis
____ Smallpox

____ Bronchitis
____ Bed-wetting
____ Cancer
____ Chest pain
____ Chronic pain
____ Colds/Coughs
____ Constipation
____ Chicken pox
____ Dental problems
____ Diabetes
____ Diarrhea
____ Hearing problems
____ Hepatitis
____ High blood pressure
____ Kidney problems
____ Measles
____ Mononucleosis
____ Mumps
____ Menstrual pain
____ Miscarriages
____ Neurological disorders
____ Nausea
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache
____ Thyroid problems
____ Vision problems
____ Vomiting
____ Whooping cough

____ Other (describe): ____

List any current health concerns: ____

List any recent health or physical changes: ____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ /week	______________________	____ No ____ Low ____ Med ____ High
Lunch	____ /week	______________________	____ No ____ Low ____ Med ____ High
Dinner	____ /week	______________________	____ No ____ Low ____ Med ____ High
Snacks	____ /week	______________________	____ No ____ Low ____ Med ____ High

Comments: ____

Current prescribed medications	Dose	Dates	Purpose	Side effects
____________	______	______	____________	________
____________	______	______	____________	________
____________	______	______	____________	________
____________	______	______	____________	________

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
____________	______	______	____________	________
____________	______	______	____________	________
____________	______	______	____________	________
____________	______	______	____________	________

Are you allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe: ____

	Date	Reason	Results
Last physical exam	________	________________________________	____________________
Last doctor's visit	________	________________________________	____________________
Last dental exam	________	________________________________	____________________
Most recent surgery	________	________________________________	____________________
Other surgery	________	________________________________	____________________
	________	________________________________	____________________
Upcoming surgery	________	________________________________	____________________

Family history of medical problems: ____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: ____

____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	__________	______	_____	_____	___	___	___	___
Barbiturates	__________	______	_____	_____	___	___	___	___
Valium/Librium	__________	______	_____	_____	___	___	___	___
Cocaine/Crack	__________	______	_____	_____	___	___	___	___
Heroin /Opiates	__________	______	_____	_____	___	___	___	___
Marijuana	__________	______	_____	_____	___	___	___	___
PCP/LSD/Mescaline	__________	______	_____	_____	___	___	___	___
Inhalants	__________	______	_____	_____	___	___	___	___
Caffeine	__________	______	_____	_____	___	___	___	___
Nicotine	__________	______	_____	_____	___	___	___	___
Over the counter	__________	______	_____	_____	___	___	___	___
Prescription drugs	__________	______	_____	_____	___	___	___	___
Other drugs	__________	______	_____	_____	___	___	___	___

Substance of preference

1. ____________________________________ 3. ____________________________________

2. ____________________________________ 4. ____________________________________

Describe when and where you typically use substances: ____________________________________

Describe any changes in your use patterns: ____________________________________

Describe how your substance use has affected your family or friends (include their perceptions of your use): ____________

____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication ____ Taste

____ Socialization ____ Other (specify): ____________________________________

How do you believe your substance use affects your life? ____________________________________

Who or what has helped you in stopping or limiting your use? ____________________________________

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe:

____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: ____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): ____________________________________

Does your body temperature change when you drink? ____ Yes ____ No If Yes, describe: ______________________

Have drugs or alcohol created a problem for your job? ____ Yes ____ No If Yes, describe: ______________________

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	__________	______________	____________________________
Suicidal thoughts/attempts	____	____	__________	______________	____________________________
Drug/alcohol treatment	____	____	__________	______________	____________________________
Hospitalizations	____	____	__________	______________	____________________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	__________	______________	____________________________

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience

Counseling/psychiatric treatment ____ ____ __________ ______________ ______________________________

Suicidal thoughts/attempts ____ ____ __________ ______________ ______________________________

Drug/alcohol treatment ____ ____ __________ ______________ ______________________________

Hospitalizations ____ ____ __________ ______________ ______________________________

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous) ____ ____ __________ ______________ ______________________________

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression
____ Alcohol dependence
____ Anger
____ Antisocial behavior
____ Anxiety
____ Avoiding people
____ Chest pain
____ Cyber addiction
____ Depression
____ Disorientation
____ Distractibility
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying

____ Other (specify): ____

Briefly discuss how the above symptoms impair your ability to function effectively: ______________________________

____

____

____

____

____

Any additional information that would assist us in understanding your concerns or problems: ____________________

____

____

____

____

____

What are your goals for therapy? ____

____

____

Do you feel suicidal at this time? ____ Yes ____ No If Yes, explain: __________________________________

____

____

____

<u>FOR STAFF USE</u>

Therapist's signature/credentials: ____ Date: ____/____/______

Printed Name: ____ License: ______________________