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ADULT INTAKE FORM

Name: _____ Date: _____

Address: _____

Phone Numbers: _____

Email: _____

What is happening in your life which resulted in this appointment?

_____

_____

_____

My top source of stress is: □ Spouse □ Children □ My Job □ Financial □ Illness □ Friendships □ Other

My second top source of stress is □ Spouse □ Children □ My Job □ Financial □ Illness □ Friendships □ Other

My third top source of stress is: □ Spouse □ Children □ My Job □ Financial □ Illness □ Friendships □ Other

Do you experience any of the following symptoms?

Depression	Feelings of Worthlessness	Sadness/Loss	Low Energy	Sleep Disturbance (more/less)
Self-Harming Behavior	Appetite Disturbance (more/less)	Low Self-Esteem	Thoughts of hurting yourself or past suicide attempts	Excessive Guilt

Do you experience any of the following symptoms?

Excessive Worry	Unpleasant Thoughts Won't Go Away	Restlessness	Irritability	Mind Going Blank
Feeling Like You Can't Turn Off Your Brain or You Can Relax	Exposure to a Traumatic Event	Victim of Child Abuse	Re-experiencing of Traumatic Event (nightmares, flashbacks, etc)	Avoidance of People, Places, or Things Related to the Trauma Event
Intrusive Thoughts	Muscle Tension	Distractibility	Excessive Fears	Compulsive Behaviors

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Do you experience any of the following symptoms?

Thoughts Racing	More Talkative Than Usual	Feeling Like You Could Accomplish Anything	Excessive Sexual Activity	Excessive Drug/Alcohol Use
Quick to Anger	Easily Agitated	Restlessness	Feeling "Out of Control"	Thoughts of Hurting Someone

Do you experience any of the following?

See or Hear Things That Others Can Not	Feelings That Things Around You Are Not Real	Beliefs About The World That Others Think Are Odd	Lose Track of Time

Have you recently experienced any of the following?

A Stressor You've Had to Adjust To	The Loss Of A Loved One	Relationship Conflict	Separation/Divorce	Victim Of A Crime

Have you been previously diagnosed with any conditions?

□ NONE □ Other _____

Are you taking any psychiatric or pain medications?

□ NONE □ Other _____

Are you currently or have you previously been addicted to any substances?

□ NONE □ Other _____

What would you like to see accomplished in therapy?

_____

_____

_____