Adult Intake Form

Thank you for taking the time to complete this form. It helps us get to know you before the first visit. Please answer as thoroughly as possible. If you're unsure about a question or it doesn't apply, feel free to skip it or write "unsure" or "N/A."

Reason for Seeking Services

What are your main concerns for your mental health?

When did you first notice these concerns?

How are these concerns affecting you at home?

How are these concerns affecting you at work?

How are these concerns affecting your relationships?

What have you tried so far to help? What has worked? What hasn't worked?

Living Situation

Who do you live with? (Please list names, relationships, and ages if applicable)

Do you have any pets? If yes, please list type and name:

Current Symptoms (Check all that apply)

Depression:

- [ ] Little interest or pleasure in doing things you used to enjoy
- [ ] Sad, down, or hopeless most of the day, nearly every day
- [ ] Trouble sleeping (too much or too little)
- [ ] Feeling tired or having little energy nearly every day
- [ ] Poor appetite or overeating
- [ ] Feeling worthless or guilty nearly every day
- [ ] Trouble concentrating, making decisions, or thinking clearly
- [ ] Moving or speaking so slowly that others noticed, or being unusually restless or fidgety
- [ ] Thoughts of death, self-harm, or suicide
- [ ] Other:

Mood Disorder:

- [ ] I have temper outbursts (yelling, slamming things, or getting physical) that feel way bigger than the situation calls for
- [ ] I feel irritable, angry, or on edge most of the time, even between outbursts
- [ ] I have had a period of at least 4 days in a row where I experienced several of the following at the same time:
  - [ ] Feeling overly confident or like I was more talented, powerful, or important than usual
  - [ ] Needing much less sleep than normal (e.g., sleeping only 2 to 4 hours) but still feeling rested and energetic
  - [ ] Talking more than usual, faster than normal, or feeling like I couldn't stop talking
  - [ ] Thoughts racing through my mind, jumping quickly from one idea or topic to another
  - [ ] Feeling easily distracted or unable to concentrate
  - [ ] Being much more active than usual, starting lots of projects, cleaning nonstop, pacing
  - [ ] Doing risky things I wouldn't normally do (e.g., reckless spending, impulsive sex, reckless driving)
- [ ] Other:

Anxiety:

- [ ] I often feel nervous, tense, or constantly worried, even when there's no clear reason
- [ ] I find it hard to control my worrying, even when I try to calm down or relax
- [ ] I've experienced panic attacks, sudden episodes of intense fear with symptoms like racing heart, chest tightness, dizziness, or shortness of breath
- [ ] I feel anxious in social situations or around unfamiliar people and worry about being judged or embarrassed
- [ ] Fear of being in places or situations where escape might be difficult or help is unavailable (like crowds, public transportation, or being alone in public)
- [ ] I have strong fears of specific things, like animals, storms, heights, the dark, blood, or needles, and try to avoid them
- [ ] My anxiety causes physical symptoms like stomach pain, headaches, muscle tension, restlessness, or feeling shaky
- [ ] Other:

Obsessive-Compulsive Disorder (OCD) and Related Symptoms:

- [ ] I have repeated, unwanted thoughts, urges, or mental images that cause a lot of anxiety or distress
- [ ] I do repetitive behaviors (like washing, checking, or touching things in a certain way) to try to reduce anxiety or feel "just right"
- [ ] I do mental rituals (like counting, praying, or repeating phrases silently) to prevent something bad or to ease anxiety
- [ ] I feel preoccupied with a flaw in my appearance that others don't notice or think is minor
- [ ] I have trouble getting rid of possessions, even things I don't need, and it causes clutter or distress
- [ ] I pull out my own hair, such as from my scalp, eyebrows, or eyelashes
- [ ] I pick at my skin repeatedly, often to the point of causing sores or scarring
- [ ] Other:

Health Anxiety and Stress-Related Physical Symptoms:

- [ ] I feel high levels of anxiety about my health
- [ ] I have physical symptoms (like pain, fatigue, stomach issues) that don't have a clear medical cause
- [ ] I worry that my symptoms might mean something serious, even when doctors say I'm okay

- [ ] I spend a lot of time thinking about my health or checking my body for signs of illness
- [ ] I sometimes avoid or frequently visit doctors because of fear about being sick
- [ ] I've had sudden symptoms like weakness, shakiness, numbness, trouble moving, or seizure-like episodes that doctors haven't been able to explain
- [ ] Other:

Psychosis (Unusual Thoughts or Perceptions):

- [ ] I hear or see things that others don't
- [ ] I get special or hidden messages from the television, radio, the internet, or other people
- [ ] I have unusual beliefs, like thinking people are trying to harm me or can hear my thoughts
- [ ] I feel paranoid, or like others are watching or following me
- [ ] I've had unusual sensory experiences (like feeling things on my skin or smelling things) when nothing was there
- [ ] Other:

Interpersonal Disorders:

- [ ] I have an intense fear of being abandoned or left alone
- [ ] My relationships are often very intense but unstable, I might adore someone one moment and hate them the next
- [ ] I often feel empty inside
- [ ] I've lied to or manipulated others to get what I want
- [ ] I don't feel guilty when I hurt or mistreat others
- [ ] I have trouble keeping a job or managing money consistently
- [ ] I feel I am more special or talented than most people
- [ ] I often fantasize about being extremely successful, powerful, or admired
- [ ] I need a lot of admiration and attention from others
- [ ] I feel I deserve special treatment
- [ ] I have difficulty understanding or caring about others' feelings
- [ ] People say I come across as arrogant or superior
- [ ] I feel uncomfortable when I'm not the center of attention
- [ ] I express my emotions in a way that others see as very dramatic or theatrical
- [ ] I think my relationships are closer or more intimate than they really are

- [ ] I often feel that others are to blame for most of my problems
- [ ] Other:

Attention and Focus:

- [ ] I had trouble paying attention or sitting still as a child
- [ ] Teachers or parents were concerned about my focus or behavior
- [ ] I struggled with reading, writing, or math, and needed extra help in school
- [ ] I was described as "daydreaming," "disruptive," or "not working to potential"
- [ ] I often have trouble staying focused on tasks at work, at home, or during conversations
- [ ] I get easily distracted by noises, thoughts, or things around me
- [ ] I tend to procrastinate or avoid tasks that require sustained focus or are boring
- [ ] I often start things but struggle to finish them
- [ ] I lose things, miss deadlines, or feel disorganized
- [ ] I often act before thinking, interrupt others, or make impulsive decisions
- [ ] I have a hard time relaxing or winding down, even when I want to
- [ ] I sometimes get into a state of "hyperfocus" where I lose track of time
- [ ] These symptoms interfere with my work, relationships, or daily responsibilities
- [ ] These symptoms have interfered with my job, such as getting written up, missing deadlines, or losing work opportunities
- [ ] Other:

Sleep Concerns:

- [ ] I have trouble falling asleep
- [ ] I wake up during the night and have trouble falling back asleep
- [ ] I experience nightmares or night terrors
- [ ] I sleep more than usual but still feel tired or unrefreshed
- [ ] I've been told I snore loudly or stop breathing during sleep
- [ ] I've had sleepwalking, sleep talking, or unusual behaviors while asleep
- [ ] Other:

Eating and Appetite:

- [ ] I restrict how much I eat or eat very little, leading to low body weight
- [ ] I have a strong fear of gaining weight or becoming fat
- [ ] I feel very upset or concerned about my body shape or appearance

- [ ] I have episodes of eating a large amount of food quickly, feeling out of control while eating (binge eating)
- [ ] I do things to prevent weight gain, like making myself vomit, using laxatives, fasting, or exercising excessively
- [ ] Other:

Sexual Health and Functioning:

- [ ] I have low or no interest in sex, even when I want to feel connected
- [ ] I have difficulty becoming aroused or maintaining arousal during sexual activity
- [ ] I have difficulty with or cannot reach orgasm
- [ ] I experience pain, discomfort, or tension during sexual activity
- [ ] These issues cause distress or affect my relationships or self-esteem
- [ ] Other:

Gender Dysphoria:

- [ ] I feel distressed about the sex I was assigned at birth
- [ ] I have a strong desire to be another gender or to live as another gender
- [ ] I prefer clothing, appearance, or roles typically associated with a different gender
- [ ] I feel uncomfortable with my body or physical characteristics related to the sex I was assigned at birth
- [ ] I feel distressed about how others perceive or refer to my gender
- [ ] Other:

Neurodivergent:

- [ ] I've always felt I miss things in conversations, like sarcasm, social cues, or "unspoken rules"
- [ ] I prefer routine and predictability, and unexpected changes really throw me off
- [ ] I have intense interests or hobbies that I can focus on for hours, sometimes to the exclusion of other things
- [ ] I'm very sensitive to certain sounds, lights, textures, or smells, even if others don't seem bothered
- [ ] People describe me as very literal, or I've been told I "overthink" things others see as simple
- [ ] I tend to take things at face value and don't always catch jokes, sarcasm, or double meanings

- [ ] I've been told I seem "awkward" or "blunt," even when I'm trying to be friendly
- [ ] Other:

Trauma History

This section asks about difficult or traumatic experiences you may have had. These experiences can affect mental health, and knowing about them helps us provide better care. Please answer as openly as you're comfortable.

Have you experienced or witnessed any of the following? (Check all that apply)

- [ ] Physical abuse
- [ ] Emotional or verbal abuse
- [ ] Sexual abuse or assault
- [ ] Neglect
- [ ] Domestic violence
- [ ] Bullying (in person or online)
- [ ] Death of a loved one (parent, sibling, spouse, close family member, or friend)
- [ ] Divorce or separation
- [ ] Serious illness or hospitalization
- [ ] Painful medical procedures
- [ ] Car accident or other serious accident
- [ ] Natural disaster
- [ ] Community violence or crime
- [ ] Combat or military trauma
- [ ] Other traumatic event:

If you checked any of the above, please provide additional details if you're comfortable:

Do you experience any of these signs related to traumatic experiences?

- [ ] Nightmares or bad dreams about the traumatic event
- [ ] Flashbacks or feeling as if the traumatic event is happening again
- [ ] Getting very upset when reminded of the traumatic event
- [ ] Physical reactions when reminded of the trauma (racing heart, sweating, feeling panicky)
- [ ] Trying to avoid thinking or talking about the traumatic event
- [ ] Avoiding people, places, or activities that remind you of the trauma
- [ ] Trouble remembering important parts of the traumatic event
- [ ] Negative thoughts about yourself, others, or the world
- [ ] Blaming yourself for the traumatic event
- [ ] Loss of interest in activities you used to enjoy
- [ ] Feeling detached or disconnected from others
- [ ] Difficulty feeling positive emotions or feeling emotionally numb
- [ ] Irritability or angry outbursts
- [ ] Reckless or self-destructive behavior
- [ ] Being overly alert or on guard (hypervigilance)
- [ ] Being easily startled or jumpy
- [ ] Difficulty concentrating
- [ ] Trouble sleeping
- [ ] Other:

Safety Assessment

Have you ever had thoughts about wanting to die or kill yourself?

- [ ] Yes
- [ ] No

If yes, when was the most recent time?

Have you ever made a suicide attempt?

- [ ] Yes
- [ ] No

If yes, please describe what happened, when, and what treatment was provided:

Have you ever intentionally hurt yourself (cutting, burning, hitting, etc.)?

☐ Yes ☐ No

If yes, please describe:

Have you ever had thoughts about wanting to hurt someone else?

☐ Yes ☐ No

If yes, please describe:

Do you have access to firearms, medications, or other means?

☐ Yes ☐ No

If yes, are they secured?

☐ Yes ☐ No

Current Medications

Please list all medications you are currently taking. Include psychiatric medications, medical medications, over-the-counter medications, vitamins, and supplements. For each, include the name, dose, and how often it's taken.

Do you take your medications as prescribed?

☐ Yes ☐ Sometimes ☐ No

If not always, what gets in the way?

Do you have any allergies to medications?

☐ Yes ☐ No

If yes, please list the medication and the reaction:

Prior Psychiatric Medications

Please list any psychiatric medications you have taken in the past, even if they didn't work or caused side effects. Include the name, approximate dates, dose if known, and response.

Antidepressants (Prozac, Zoloft, Lexapro, etc.):

Mood Stabilizers (Lithium, Depakote, Lamictal, etc.):

Antipsychotics (Abilify, Risperdal, Seroquel, etc.):

Stimulants (Adderall, Ritalin, Vyvanse, Concerta, etc.):

Non-Stimulants for ADHD (Strattera, Intuniv, Kapvay, etc.):

Anxiety Medications (Hydroxyzine, Buspar, Xanax, Ativan, etc.):

Sleep Aids (Melatonin, Trazodone, Ambien, etc.):

Medications for addiction:

Other Medications:

Preferred Pharmacy

If medications are prescribed, please provide your preferred pharmacy information:

Pharmacy Name:

Pharmacy Address:

Psychiatric History

Are you currently seeing a therapist?

☐ Yes ☐ No

If yes, please provide:

Therapist Name:

Practice or Agency:

How long have you been seeing this therapist?

Have you seen other therapists in the past?

☐ Yes ☐ No

If yes, please list names and approximate dates:

Have you ever been hospitalized for mental health reasons?

☐ Yes ☐ No

If yes, please provide dates, hospital name, and reason:

Have you ever been to the emergency room for a mental health crisis?

- [ ] Yes
- [ ] No

If yes, please describe:

Have you participated in any of the following programs?

- [ ] Intensive Outpatient Program (IOP)
- [ ] Partial Hospitalization Program (PHP)
- [ ] Day Treatment
- [ ] Residential Treatment
- [ ] DBT Program
- [ ] Other:

If yes, please describe when and where:

Have you had any psychological or neuropsychological testing?

- [ ] Yes
- [ ] No

If yes, please describe what was tested and what the results showed:

Developmental History

Were there any complications during your mother's pregnancy with you?

☐ Yes ☐ No ☐ Don't know

If yes, please describe if known:

Were there any complications during your birth or delivery?

☐ Yes ☐ No ☐ Don't know

If yes, please describe if known:

Were you born full-term, premature, or past due?

☐ Full-term ☐ Premature ☐ Past due ☐ Don't know

Did you meet developmental milestones on time (sitting, walking, talking, etc.)?

☐ Yes ☐ No ☐ Don't know

If no, please describe any delays if known:

Were there any early concerns about your development or behavior as a child?

☐ Yes ☐ No ☐ Don't know

If yes, please describe:

Substance Use History

Have you ever used alcohol, tobacco, nicotine, vaping products, marijuana, or other drugs?

☐ Yes ☐ No

If you answered no, you may skip the rest of this section.

Do you currently use or have you ever used alcohol?

☐ Yes, currently ☐ Yes, in the past ☐ No

If yes, please describe how much, how often, and when you last used:

Do you currently use or have you ever used tobacco, nicotine, or vaping products?

☐ Yes, currently ☐ Yes, in the past ☐ No

If yes, please describe:

Do you currently use or have you ever used marijuana or THC products?

☐ Yes, currently ☐ Yes, in the past ☐ No

If yes, please describe:

Have you ever used other drugs (cocaine, methamphetamine, hallucinogens, prescription drugs not prescribed to you, etc.)?

☐ Yes, currently ☐ Yes, in the past ☐ No

If yes, please describe:

Have you had concerns about your substance use?

☐ Yes ☐ No

If yes, please describe:

Have you ever received treatment for substance use?

☐ Yes ☐ No

If yes, please describe:

Medical History

Do you have a primary care provider?

☐ Yes ☐ No

If yes, please provide:

Provider Name:

Clinic Name:

Date of last visit:

Do you have any current or past medical conditions? (asthma, diabetes, seizures, heart problems, thyroid problems, etc.)

☐ Yes ☐ No

If yes, please list:

Have you ever had surgery?

☐ Yes ☐ No

If yes, please list the type of surgery, year, and reason:

Have you ever had a head injury or concussion?

☐ Yes ☐ No

If yes, please describe:

Have you ever had seizures or been diagnosed with epilepsy?

☐ Yes ☐ No

If yes, please describe:

Family History

Important: Please only include biological family members (blood relatives) in this section. Do not include step-parents, step-siblings, adoptive relatives, or relatives by marriage.

Does anyone in your biological family have a history of any of the following? Please include the relationship to you (mother, father, sibling, grandmother, uncle, etc.) and the condition.

Depression:

Anxiety:

Bipolar Disorder:

Schizophrenia or Psychosis:

ADHD:

Autism:

Obsessive-Compulsive Disorder (OCD):

Eating Disorders:

PTSD:

Substance Use Disorder or Addiction:

Suicide or Suicide Attempts:

Other Mental Health Conditions:

Medical Conditions (diabetes, heart disease, thyroid problems, cancer, neurological conditions, etc.):

Cardiac Family History:

Please indicate if anyone in your biological family (parents, siblings, grandparents, aunts, uncles) has a history of the following heart-related conditions, especially if diagnosed before age 50:

Has anyone in the family had any of the following? (Check all that apply)

- [ ] Connective tissue disorders (like Marfan syndrome, Ehlers-Danlos syndrome)
- [ ] Cardiomyopathies (heart muscle disease)

- [ ] Arrhythmias (irregular heart rhythms)
- [ ] Need for pacemaker or defibrillator implantation
- [ ] Storage diseases (like Pompe disease, Fabry disease)
- [ ] Sudden unexplained death (especially in someone young or during exercise)
- [ ] Heart attack (MI) or stroke (CVA) before age 50
- [ ] Congenital heart defects (born with heart problems)
- [ ] Other premature cardiovascular disease before age 50
- [ ] None of the above

If you checked any of the above, please provide details (who in the family, what condition, age at diagnosis):

Do you have any personal history of cardiac problems?

- [ ] Yes
- [ ] No

If yes, please describe:

Employment and Education

What is your current employment status?

- [ ] Employed full-time
- [ ] Employed part-time
- [ ] Self-employed
- [ ] Unemployed
- [ ] Student
- [ ] Retired

- [ ] Disabled/unable to work
- [ ] Stay-at-home parent
- [ ] Other:

If employed, what is your occupation/job title?

If employed, where do you work?

What is your highest level of education?

- [ ] Some high school
- [ ] High school diploma or GED
- [ ] Some college
- [ ] Associate's degree
- [ ] Bachelor's degree
- [ ] Master's degree
- [ ] Doctoral degree
- [ ] Trade/vocational training
- [ ] Other:

Relationship and Social History

What is your current relationship status?

- [ ] Single
- [ ] In a relationship
- [ ] Married
- [ ] Separated
- [ ] Divorced
- [ ] Widowed

Do you have children?

- [ ] Yes
- [ ] No

If yes, please list names and ages:

Do you have close friends or a support system?

- [ ] Yes
- [ ] No

What do you enjoy doing for fun?

What are your strengths? What do you do well?

Are you involved in any activities, hobbies, or interests?

Do you have cultural, religious, or spiritual practices that are important to you?

Do you have military history?

☐ Yes ☐ No

If yes, please include branch, years of service, deployments, discharge type, and any service-connected conditions:

Legal History

Have you ever had legal involvement? (arrests, probation, court-ordered services, etc.)

☐ Yes ☐ No

If yes, please describe:

Are there any current legal matters?

☐ Yes ☐ No

If yes, please describe:

Additional Information

Is there anything else you'd like us to know that we haven't asked about?

What are your goals for treatment? What would you like to see improve?