

## ADULT INTAKE FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Please answer these questions as completely as possible. You can discuss any topic more fully when you met with your therapist. It is your choice whether or not to answer any question. The purpose is to help your therapist understand you, your background, and your concerns.*

Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you most want to address:

Do you have any of the following symptoms regularly or severely enough to cause you concern?  
*Please complete by assigning a number to each problem listed, using the key below. Leave blank if you've never had the symptom. Use space next to an issue to provide more information, if you wish.*

- 1 - In the past, but not now
- 2 - Some of the time
- 3 - Most of the time
- 4 - All of the time

\_\_\_\_ ADD or ADHD concerns (even if undiagnosed)

\_\_\_\_ Adoption issues

\_\_\_\_ Alcohol or chemical abuse/dependency

\_\_\_\_ Anger issues

\_\_\_\_ Anorexia/bulimia/eating issues (binging, under/over-eating)

\_\_\_\_ Anxiety/panic attacks

\_\_\_\_ Attempting suicide

\_\_\_\_ Avoidance of conflict

\_\_\_\_ Bi-polar concerns

\_\_\_\_ Body issues

\_\_\_\_ Childcare/parenting

\_\_\_\_ Child development/behavior problems

\_\_\_\_ Cigarette addiction

- \_\_\_ Codependency
- \_\_\_ Communication problems
- \_\_\_ Compulsive/addictive behavior
- \_\_\_ Concern about another's alcohol or chemical use
- \_\_\_ Cyber/internet sex/pornography, computer gaming or online issues (i.e. over-use, compulsivity)
- \_\_\_ Depression
- \_\_\_ Dissociation
- \_\_\_ Divorce/separation
- \_\_\_ Elder parent issues
- \_\_\_ Fear/sense of not being safe
- \_\_\_ Feeling ashamed
- \_\_\_ Feeling guilty
- \_\_\_ Feeling sad
- \_\_\_ Feeling suicidal
- \_\_\_ Financial problems/concerns
- \_\_\_ Gender identity concerns
- \_\_\_ Isolation
- \_\_\_ Jealousy
- \_\_\_ Legal problems
- \_\_\_ Loneliness
- \_\_\_ Loss of concentration
- \_\_\_ Loss of energy
- \_\_\_ Loss/grief issues
- \_\_\_ Low self-esteem
- \_\_\_ Marital/couple conflict

- Mood swings
- Neglect
- Occupational/job problems
- Parent/child issues
- Physical health issues
- Physically/sexually abused as an adult
- Physically/sexually abused as a child
- School-related problems
- Self-hate/self-loathing
- Self-injury
- Sexual identity/orientation
- Sexual relationship issues
- Sexuality concerns
- Single parenting issues
- Step-family issues
- Verbal/emotional abuse
- Other

Have your symptoms impacted your daily functioning or caused you any problems at school, work or home? Please describe:

How would you describe your emotional health at the present time?

Poor  Fair  Average  Good  Excellent

Have you sought therapy at other times in your life?  Yes  No

From when to when? \_\_\_\_\_

With whom? \_\_\_\_\_ Was your experience helpful to you? \_\_\_\_\_

Please describe any current or significant past stressors in your life (school, work, relationships, financial, etc.)

Are you aware of any family history of alcoholism, addiction, depression, anxiety, bi-polar, schizophrenia, or other mental illness? \_\_\_ Yes \_\_\_ No Please describe:

**Chemical Health History**

Describe your current alcohol/drug use:

Amount? \_\_\_\_\_ Frequency? \_\_\_\_\_

Have others expressed concern about your alcohol or drug use? \_\_\_ Yes \_\_\_ No Who? \_\_\_\_\_

Have there been any negative consequences as a result of your alcohol or drug use? For example, DUIs, arrests, relationship difficulties, etc?

Previous treatment? \_\_\_ Yes \_\_\_ No If yes, where and when? \_\_\_\_\_

Are you worried about the drug or alcohol use of a significant person in your life - i.e. spouse, parent, child, sibling? \_\_\_ Yes \_\_\_ No If yes, please describe your concern:

**Identity/Relationship Status**

How do you identify your sexual orientation?

Are you: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ In a significant relationship

Please list the names and ages of the people you live with and their relationship to you:

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Please list the names and ages of any children you have who aren't living with you currently:

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Family History: Please provide the names and current ages of your parents or primary caregivers and your siblings. *If deceased, please indicate age and date of death.*

Parents/Caregivers:

Siblings:

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Please list any other significant adults who impacted your childhood:

**Legal History:**

Have you had any current or past problems with the legal system? Please describe:

Are you currently involved in any legal action/litigation?

Do the reasons you are seeking services at Lakewood have to do with legal issues? Please describe:

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How satisfied are you with your occupation? \_\_\_\_\_

Highest level of education achieved: \_\_\_\_\_

Interests/activities: *Please describe interests or hobbies and how you spend time during a typical day.*

Personal strengths/challenges: *Do you have any attributes that you consider to be strengths and are there areas you identify as being difficult for you?*

How would you describe your physical health at the present time?

Poor  Fair  Average  Good  Excellent  Not sure

Explain:

Date of your last physical exam and name of your physician and/or psychiatrist. Which clinic/office?

Current medications:

Name	For what condition	Date began	Dosage

Have you experienced any significant illnesses, accidents or surgeries? Please describe:

Describe the physical fitness program you follow, if any:

**Spiritual/Religious Belief System:**

Do you actively participate in a faith community?  Yes  No If yes, please identify that community:

How important is your faith to you?

What kind of a support system do you have?

**Is there anything more that you want to share?**

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to you \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_