SAMANTHA WIDMAN, LMFT

PSYCHOTHERAPY

Adult Intake Form

Name: ______________________________________ Age:____________

Date: _______________ Best phone # to contact you at: ________________________

Please answer these questions as completely as possible. You can discuss any topic more fully when you meet your therapist. It is your choice whether or not you answer any specific question(s). The purpose of this form is to help your therapist understand you, your background, and your concerns. THIS IS FOR YOUR THERAPIST ONLY.

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

Describe what you have already done to try and deal with your concerns:

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Please complete by assigning a number to each problem listed, using the key below. Leave blank if you've never had the symptom. ***<u>Use space next to an issue to provide more information, if you wish.</u>***

1 - In the past, but not now	**2 - Some of the time (current)**
3 - Most of the time (current)	**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) _____ 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	Comments:

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1 - In the past, but not now	**2 - Some of the time (current)**
3 - Most of the time (current)	**4 - All of the time**
_____ 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 – please elaborate:	Comments:

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

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

____ Poor ____ Fair ____ Average ____ Good ____ Excellent

Comments:

Please describe any current or past significant 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 If yes, please describe:

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Chemical Health History

(Alcohol, Illegal Substances, Non-Prescribed Substances, Tobacco, etc.)

Substance	Age When 1st Tried	Date of most recent Use	Frequency of Use in Last Six Months (how often)	Amount Used Typically

Have there been any negative consequences as a result of your chemical use? (i.e., DUI's, arrests, charges, relationship difficulties, etc.) If yes, please describe:

Have others expressed concern about your alcohol or drug use? ____ Yes ____ No
If yes, please describe:

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:

How do you identify your sexual orientation?

____

Are you: ____ Single ____ Married ____Divorced ____ Widowed

____ In a significant relationship

Comments:

Describe any comments or concerns regarding your living situation:

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? Please describe:

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

Work/Education

Occupation/Title: ___________________________ Employer:____________________________

Comments:

How satisfied are you with your occupation and why?:

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High School Attended: ______________________________ Year of Graduation: ____________

College/University: _________________________________ Year of Graduation: ____________

College/University: _________________________________ Year of Graduation: ____________

Degree(s) Earned and Major(s):

____

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

Described your attributes that you consider to be strengths:

Described your attributes that you consider to be a source of weakness, frustration or concern (for you or others):

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

____ Poor ____ Fair ____ Average ____ Good ____ Excellent ____ Not sure

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Medical Information

Name of Primary Physician: ____

Phone:# ____

Name of Clinic:____

Date and Reason of Last Physical Exam: ______________________________________

____

Current Medication(s):

Name	Dosage	Prescriber/Clinic	Date(s)

Previous Medications(s):

Name	Dosage	Prescriber/Clinic	Date(s)

Previous Therapist(s):

Name/Clinic	Date(s)	Comment(s)

What HAS worked for you in therapy? Describe:

What has NOT worked for you in therapy? Describe:

Previous Hospitalizations, Partial Hospitalizations, Day Treatments, CD Treatments, etc:

Name/Clinic/Facility	Date(s)	Comment(s)

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 spiritual/faith community? ____ Yes ____ No

If yes, please identify/describe 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?