BOTH /AND Resources
Adult Intake Form

PLEASE COMPLETE AS THOROUGHLY AS POSSIBLE

Name _____ **Age** _____
Date of Birth _____
Referred by: _____ **Today's Date** _____

CURRENT SITUATION

1. Describe the concerns that led you to seek therapy.
_____
_____
_____
_____

2. Describe what you have already done to try and deal with your concerns.
_____
_____
_____
_____

3. Describe what you hope to accomplish and/or change in therapy.
_____
_____
_____
_____

4. Name your strengths, areas of interest, things you do well, or activities you enjoy._____
_____
_____
_____

5. Please list your sources of community and personal support.
_____
_____
_____
_____

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LIVING SITUATION, OCCUPATION, LEGAL ISSUES

1. Living Situation
   _____ with spouse/partner/significant other (please circle one)
   _____ alone _____ with roommate _____ with children
   _____ with parents _____ other

Please list any family members or other persons who are currently living with you. (use other side if more room is needed)
Name:_____ Age:_____
Relationship: _____ Relational Status: good fair poor

Name: _____ Age:_____
Relationship: _____ Relational Status: good fair poor

Name: _____ Age: _____
Relationship: _____ Relational Status: good fair poor

Please list significant family members or other persons who **do not** currently live with you.
Name: _____ Age: _____
Relationship: _____ Relational Status: good fair poor

Name: _____ Age: _____
Relationship: _____ Relational Status: good fair poor

Name: _____ Age: _____
Relationship: _____ Relational Status: good fair poor

2. Occupation (please check all that apply)
   ___ Homemaker ___ Employment (describe) _____
   ___ Student ___ Volunteer (describe) _____

3. Highest level of education _____

4. Legal Issues
   Have you been in jail, prison, or juvenile detention? Yes No
   If yes, please describe _____
   _____
   Have you been arrested or convicted without incarceration? Yes No
   If yes, please describe _____
   _____

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RISK CONCERNS

1. Do you currently have suicidal thoughts? Yes No
   If so, do you have a plan? N/A Yes No
   What is the plan? _____

2. Have you had suicidal thoughts in the past? Yes No

3. Have you attempted suicide? Yes No
   If so, when and how did you make the attempt(s)? _____
   _____

4. Do you drink alcohol? Yes No
   If so, how often? _____
   How much on each occasion? _____

5. Do you use illegal drugs? Yes No
   If so, what do you use? _____
   How often do you use? _____

6. Have you used illegal drugs in the past? Yes No
   If so, what have you used? _____

7. Have you abused or misused prescription medication? Yes No
   If so, what medications? _____

8. Do you or does anyone close to you have concerns about your use of alcohol, drugs, or prescription medications? Yes No

9. Do you have concerns about the substance use of anyone close to you? Yes No
   Whom? _____ currently in the past

10. Have you had any treatment for substance abuse? Yes No
    If so, where? _____
    When? _____

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MENTAL HEALTH HISTORY

1. Name of Therapist _____
   _____ current previous: from _____ to _____

2. Name of Psychiatrist _____
   _____ current previous: from _____ to _____

3. Medication
   current _____
   previous _____

4. Have you been hospitalized for mental health treatment? Yes No
   If so, when? _____
   Where? _____

MEDICAL HISTORY

1. Do you have a primary care physician? Yes No
   Name: _____
   Date of last exam? _____

2. Do you have allergies? Yes No
   If so, please describe _____

3. Do you exercise regularly? Yes No

4. Are you having any sleep problems? Yes No
   If so, please describe _____

5. Are you experiencing any current medical problems? Yes No
   If so, please describe _____
   _____

ADDITIONAL INFORMATION (optional)

1. Religion / Spirituality _____

2. Race / Ethnicity _____

3. Any other information you would like your therapist to know? _____
   _____
   _____
   _____