Adult Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please submit this paperwork before your first appointment.

For Psychiatric Appointments, please bring any available medical records and prescription history to your first appointment.

Personal & Contact Information

Legal Name: ______________________________
(Last) (First) (Middle)

Is this the same name on your insurance card? ☐ Yes ☐ No, name on insurance: ______________

Preferred Name If Different From Above: ______________

Birthdate: ______________ Age: __________ SSN (*last 4 digits only*): ________

Address: ______________________________
(Street and Number) (City/ State/ Zip)

Home Phone: ______________ Messages ok? ☐ Yes ☐ No

Cell/ Other Phone: ______________ Messages ok? ☐ Yes ☐ No

Email: ______________________________

Emergency Contact Name (*required*): ______________ Relationship: ______________

Emergency Contact Number: ______________________________

Please note- in order to speak with this person for purposes other than emergencies, a completed and signed Authorization For Use Or Disclosure of Protected Health Information must be on file.

Referred By: ______________________________

Gender Identity: ☐ Woman ☐ Man ☐ Trans MTF ☐ Trans FTM ☐ Genderqueer ☐ Other: __________

Sex Assigned At Birth (Administrative Sex): ☐ Female ☐ Male ☐ Intersex ☐ Other: __________

Sexual Orientation: ☐ Asexual ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Queer ☐ Questioning ☐ Other: __________

Pronouns: ☐ She/ Her ☐ He/ His ☐ They/ Them/ Their ☐ Zie/ Hir ☐ Other: __________

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed**General Health &**

Mental Health Information

1. How would you rate your current physical health? Please choose one:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing: ______

2. How would you rate your current sleeping habits? Please choose one:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing: ______

3. How many times per week do you generally exercise? ______

In what types of exercise fo you participate? ______

4. Please list any difficulties you experience with your appetite or eating patterns: ______

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes, for approximately how long?: ______

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? No ☐ Yes, when did this begin?: ______

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes, please describe: ______

8. How often do you consume alcohol? Please choose one

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

9. How often do you engage in recreational drug use? Please choose one

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes, for how long? ______

On a scale of 1—10 (10 being the best), how would you rate your relationship? ______

11. What significant life changes or stressful events have you experience recently? ______

12. Have you previously received any type of mental health services (therapy, psychiatric care, etc.)?

☐ No ☐ Yes, previous therapist/ psychiatric provider: ______

13. Are you currently taking any prescribed medications?

☐ No ☐ Yes, please list: ______

14. Have you previously been prescribed psychiatric medications?

☐ No ☐ Yes, please list and include dates: ______

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/ Substance Abuse: ☐ No ☐ Yes: ______
Anxiety: ☐ No ☐ Yes: ______
Depression: ☐ No ☐ Yes: ______
Domestic Violence: ☐ No ☐ Yes: ______
Eating Disorders: ☐ No ☐ Yes: ______
Obesity: ☐ No ☐ Yes: ______
Obsessive Compulsive Disorder: ☐ No ☐ Yes: ______
Schizophrenia: ☐ No ☐ Yes: ______
Suicide Attempts: ☐ No ☐ Yes: ______

Additional Information

1. Are you currently employed? ☐ No ☐ Yes, where: ______

   Do you enjoy your work? Is there anything stressful about your current work? ______

2. Are you currently a student? ☐ No ☐ Yes

   Where are you enrolled and what degree/ program are you pursuing? ______

3. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes, please describe below

4. What do you consider to be some of your strengths?

5. What do you consider to be some of your weaknesses?

6. What would you like to accomplish out of your time receiving services?

For Psychiatric Appointments Only

1. Do you have a preferred pharmacy? ☐ No ☐ Yes

   (Pharmacy Name) (Location)

2. Do you have a Primary Care Provider? ☐ No ☐ Yes

   (Provider/ Practice Name) (Phone Number)

3. Do you have any allergies (food, medical/ drug, environmental)? ☐ No ☐ Yes, please describe below