1900 Byrd Ave Suite 200
Richmond VA 23230
(804) 592-6311

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

Name: _____
(Last) (First) (Middle)

Birth Date: _____/_____/_____ Age: _____ Gender: _____ Nickname: _____

Marital Status:
☐ Never Married ☐Domestic Partnership ☐Married ☐Separated ☐Divorced ☐Widowed

Address: _____
(Street and Number)

_____ Home Phone: ( ) _____ Messages ok? ☐Yes ☐No
(City/State/Zip)

Cell/Other Phone: ( ) _____ Messages ok? ☐Yes ☐No

Email: _____ May we email you? ☐Yes ☐No

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: ( ) _____

Referred By: _____

Have you previously received any type of mental health services (therapy, psychiatric care, etc.)?
☐No
☐Yes, previous therapist/psychiatric provider: _____

Are you currently taking any prescribed medication?
☐No
☐Yes, please list: _____
_____

Have you ever been prescribed psychiatric medication?
☐No
☐Yes, please list and include dates:
_____
_____

General Health & Mental Health Information:

1. How would you rate your current physical health (please circle 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 circle 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: _____

What types of exercise do you participate in: _____

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, if so, for approximately how long? _____

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

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

8. Do you drink alcohol more than once a week? ☐No ☐Yes
9. How often do you engage in recreational drug use? ☐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 experienced recently:
_____
_____
_____

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.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no……	
Anxiety	yes/no……	
Depression	yes/no……	
Domestic Violence	yes/no……	
Eating Disorders	yes/no……	
Obesity	yes/no……	
Obsessive Compulsive Disorder	yes/no……	
Schizophrenia	yes/no……	
Suicide Attempts	yes/no……	

Additional Information:

1. Are you currently employed? ☐No ☐Yes
If yes, what is your current employment situation?

_____

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

_____
_____

2. Are you currently a student? ☐No ☐Yes
If Yes, where are you enrolled and what degree/program are you pursuing?

_____

3. Do you consider yourself to be spiritual or religious? ☐No ☐Yes, if so, describe your faith or belief:

_____

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 in therapy/psychiatric services?
_____
_____
_____

For Psychiatric Appointments Only:

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

_____
(Pharmacy Name) (Location)

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

_____
(Provider/Practice Name) (Phone Number)

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

_____