Integrated Therapy Services

Adult Information Intake Form

Please answer the following as completely as possible. Use the back if additional space is needed.

Client Name: _____ Date: _____
(Last) (First) (Middle Initial)

Gender: F___ M___ Ethnicity:_____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (cell) _____ (work) _____
Ok to leave a message? YES / NO YES / NO YES / NO

In the event of an emergency contact: _____ Phone: _____

Occupation/Company: _____

Marital Status: Single / Married / Separated / In Process of Divorce / Divorced / Widowed / In a Committed Relationship

Client Resides With:

_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*

Additional Family Members / Caregivers:

_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*

Referred to this office by: _____

Physician's Name: _____ Phone:_____

Date last Seen: _____ Reason: _____

Medications: _____

Allergies: _____

Medical Issues/Surgeries/Accidents: _____

_____

Previous Counseling? Yes/No If yes, with whom: _____))_____When:_____

Reason for previous counseling: _____

_____

Psychiatrist Name: _____ Phone: _____

Have you ever been hospitalized for mental health reasons? Yes/No

If yes, Where? _____ When? _____

Reason: _____

Did you reach developmental milestones at age appropriate times? Yes/No

If no, please explain: _____

Please describe any difficulties related to pregnancy/birth/postpartum: _____

_____

Circle any of the following that are supportive influences in your life:

Extended family	Faith based support	Cultural or ethnic resources
Other counselors	Doctor	Physical therapy
Employer	School	Child care
Friends	Community Resources	Other: _____

Circle any of the following you have experienced or been involved with:

Physical Abuse	Emotional Abuse	Sexual Abuse	Traumatic Accident
Theft	Assault	Suicide Attempt	Death of a Loved One
Major Illness	Surgery	Disability	Separation
Miscarriage	Abortion	Homelessness	Incarceration
Drug Use	Eating Disorders	Gender Identity	Domestic violence

Other: _____

Are there any concerns with: (if yes, please explain)

Drug/Alcohol Use- Yes/No _____

Mental Health- Yes/No _____

Video Games/Internet Use- Yes/No _____

Parenting- Yes/No _____

Marital or Relationship(s) - Yes/No _____

Employment /Work - Yes/No _____

What are some of your strengths? What do you like about yourself?_____

_____

_____

In the past 2 to 4 weeks have you noticed any of the following:

Hyperactivity	Aggression	Irritability	Feeling Anxious
Apathetic	Obsessions	Crying Spells	Sleeping Problems
Excessive Worry	Fatigue	Depression	Memory Problems
Phobias	Lying	Weight Loss/Gain	Unfaithful to Spouse
Restlessness	Feeling Conflicted	Nightmares	Problems Concentrating

Other(s):_____

<u>How often</u> have you experienced the following problems recently?

	Not at All	Hardly Ever	Yes Sometimes	Yes Often
I have felt little interest or pleasure in things	☐	☐	☐	☐
I have been able to laugh and see the funny side of things	☐	☐	☐	☐
I have felt down, depressed, or hopeless	☐	☐	☐	☐
I have had trouble falling or staying asleep	☐	☐	☐	☐
I have been sleeping too much	☐	☐	☐	☐
I have had a poor appetite or been overeating	☐	☐	☐	☐
I have felt bad about myself/ felt like a failure	☐	☐	☐	☐
I have felt like I've let myself and/or my family down	☐	☐	☐	☐
I have had trouble concentrating on things	☐	☐	☐	☐
I have blamed myself unnecessarily when things went wrong	☐	☐	☐	☐
Thing have been too much for me to cope with	☐	☐	☐	☐
I have been fidgety or restless	☐	☐	☐	☐
I have been anxious or overly worried	☐	☐	☐	☐
I have felt sad or miserable	☐	☐	☐	☐
I have been so miserable that I have been crying	☐	☐	☐	☐
I have felt scared or panicky	☐	☐	☐	☐

I have had thoughts that I would be better off dead	☐	☐	☐	☐
The thought of harming myself has occurred to me	☐	☐	☐	☐
The thought of harming someone else has occurred to me	☐	☐	☐	☐

How bothered have you been recently by the following problems?

	Not Bothered	Bothered a little	Bothered a lot
Worrying about your health	☐	☐	☐
Your weight or how you look	☐	☐	☐
Little or no sexual desire or pleasure during sex	☐	☐	☐
Difficulties in relationship with partner/spouse	☐	☐	☐
Difficulties in relationships with others (i.e. family/friends)	☐	☐	☐
The stress of taking care of children, parents, or other family members	☐	☐	☐
Stress outside of your home (i.e. work/school)	☐	☐	☐
Financial problems or worries	☐	☐	☐
Having no one to turn to when you have a problem	☐	☐	☐
Something bad/upsetting that has happened	☐	☐	☐
Thinking or dreaming about something bad that happened in your past	☐	☐	☐

For Women Only:

Which best describes your menstrual periods?

☐ Periods are periods\unchanged recently gave birth	☐ No Periods because pregnant	☐ Irregular or changed in amount, frequency, or duration	☐ No period for at least a year	☐ Having and taking HRT or oral contraceptives

During the week prior to your period starting, do you have a serious problem with your mood (i.e. depression, anxiety, irritability, anger or mood swings? ☐ No ☐ Yes

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How would you rate your over all functioning? (circle one)

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Unable to function in all areas		Unable to function in most areas		Serious difficulty functioning			Mild to moderate difficulty	Minimal difficulty	No difficulty

Are you concerned with any of the following:

Suicidal thoughts, plans, attempts? _____

Fear for your life or your safety? _____

Depression/Lack of care for self? _____

_____

TREATMENT PLAN - Briefly state why you are seeking counseling. What do you hope to change?
Our goals for counseling are:

1.

2.

3.

Additional Notes:

In signing below, I affirm that the information given is true and complete to my knowledge.

_____ _____
Client Signature ***Date***

_____ _____
Provider Signature ***Date***