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ADULT INTAKE FORM

Date ____________________

Name ____
First Middle Last

Date of Birth___________________ Age_______________

Address ____

Home Phone ______________________________________ Do I have permission to call you? ❑Yes ❑No

Cell Phone ______________________________________ Do I have permission to call you? ❑Yes ❑No

E-mail ____ Do I have permission to e-mail you? ❑Yes ❑No

Sex/Gender ____________________ Race/Ethnicity____

Relationship Status: ❑Single ❑Significant Relationship ❑Married/Partnered ❑Separated ❑Divorced ❑Widowed ❑Other____

Children: ❑Yes ❑No Please list their ages and genders: ______________________________

Disabilities/Illnesses (if any)____

Financial Status: ❑Comfortable ❑Some Stress ❑Severe Stress __________________________________

Spiritual/Religious Affiliation (if any) ____

Are you employed outside the home?__________ What kind of job? ____________________ Where? ___________________

Are you a student?________________________ Where? ___________________________ Your degree/major? __________

EMERGENCY CONTACT

Name ____

Relationship to You _______________________ Phone Number ____

REFERRAL SOURCE

How did you hear about my practice? (check all that apply)

❑Self ❑Flyer/Pamphlet ❑Website ❑Google ❑Parent/Family Member ❑ Friend/Colleague
❑Other Counselor/Therapist ❑Medical Provider ❑Treatment Program
❑Other: ____

OK to thank referrer? ❑Yes ❑No Name of Referrer (person or agency) ________________________________

Address of Referrer (if known) ____

Phone # of Referrer (if known) ____

CHECKLIST OF CONCERNS/REASONS FOR SEEKING THERAPY SERVICES

Please mark all of the items below that apply to you. You may add other items at the end if needed. Also feel free to add a note or details in the space next to any of the concerns that you checked.

Addictions & Obsessions/Compulsions (thoughts or actions that repeat)

- ❑ Alcohol use
- ❑ Cleanliness
- ❑ Counting
- ❑ Eating (bingeing, purging. overeating, undereating)
- ❑ Dieting/exercise
- ❑ Drug use (including prescription and over-the-counter meds, street drugs)
- ❑ Gambling
- ❑ Hoarding
- ❑ Love addiction (i.e., can't go without being in a relationship, sequentially or concurrently)
- ❑ Perfectionism
- ❑ Pornography
- ❑ Sexual activity, hyper-sexualized behaviors
- ❑ Shopping/spending
- ❑ Shoplifting
- ❑ Smoking/tobacco use
- ❑ Weight/body image
- ❑ Other ____

Age, Gender & Sexuality Concerns

- ❑ Concerns about your age, aging, age discrimination
- ❑ Gender discrimination
- ❑ Gender identity
- ❑ Sexual orientation
- ❑ Sexual dysfunction
- ❑ Sexual harassment/exploitation
- ❑ Sexual health
- ❑ Sexual risk-taking
- ❑ Sexual satisfaction

Beliefs/Values. Ethical Issues, & Spiritual/Religious Concerns

- ❑ Confusion about beliefs, values
- ❑ Moral/ethical issues
- ❑ Sense of foreshortened future
- ❑ Spiritual/religious concerns

Cognitive Functioning

- ❑ Attention span/concentration problems
- ❑ Confusion & thought disorganization
- ❑ Decision-making, indecision, avoidance
- ❑ Delusions (false ideas)
- ❑ Judgment problems, risk-taking
- ❑ Memory problems
- ❑ Suspiciousness/paranoia

Emotion & Mood Regulation

- ❑ Anger, hostility, irritability, low frustration tolerance
- ❑ Aggression, violence
- ❑ Anxiety, nervousness, tension
- ❑ Depression, low mood, crying, sadness, low motivation

- ❑ Emptiness
- ❑ Fears/phobias
- ❑ Flashbacks of traumatic event(s)
- ❑ Grief/mourning of deaths, losses, divorce, etc.
- ❑ Guilt
- ❑ Helplessness/powerlessness
- ❑ Homesickness
- ❑ Hopelessness
- ❑ Hyperactivity (extremely high energy)
- ❑ Hypersensitivity (easily hurt or upset; feel things very deeply)
- ❑ Hypervigilance (constantly on high alert, jumpy and reactive)
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Inferiority feelings
- ❑ Loss of interest/motivation
- ❑ Loneliness
- ❑ Mood swings
- ❑ Hypersensitivity
- ❑ Nightmares/distressing dreams
- ❑ Numb feelings/no feelings
- ❑ Panic or anxiety attacks
- ❑ Pessimism, negativity
- ❑ Stress, stress management, stress disorder, tension
- ❑ Sudden behavioral changes
- ❑ Withdrawal, isolating

Family Problems

- ❑ Addictions of family members (please specify)____
- ❑ Care of elders
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Marital conflict/distance/disappointments; infidelity/affairs; separation/divorce; remarriage
- ❑ Parenting, child management, single parenting, child custody
- ❑ Extended-family stressors

Financial

- ❑ Money troubles, debt, low income
- ❑ Other financial concerns

Harm of Self/Others

- ❑ Suicidal thoughts (please describe)____
- ❑ Suicidal action/attempt (please describe)____
- ❑ Homicidal thoughts/actions (please describe)____
- ❑ Thoughts of self-injury (e.g., cutting or any behaviors designed to release tension or overwhelming feelings) (please describe)____
- ❑ Self-injury behaviors (please describe) ____

Interpersonal Functioning in Relationships

- ❑ Assertiveness issues
- ❑ Codependence/dependence
- ❑ Commitment/intimacy issues
- ❑ Problems with friends, relatives, or coworkers
- ❑ Problems in romantic relationship(s)
- ❑ Self-centeredness

- ❑ Self-esteem/self-confidence
- ❑ Shyness, social phobia
- ❑ Oversensitivity to criticism, rejection
- ❑ Unreliable/irresponsible
- ❑ Unstable/unreliable partner history

Judicial/Legal Issues (Against you or filed by you)

- ❑ Legal matters, charges, suits
- ❑ Criminal charges
- ❑ Judicial/police/court actions

Physical Health

- ❑ Chronic illness or disease
- ❑ Chronic pain
- ❑ Disability
- ❑ Fatigue, tiredness, low energy
- ❑ Headaches, migraines
- ❑ Hormonal or menstrual problems (e.g. PMS, menopause)
- ❑ Other medical concerns or physical problems
- ❑ Self-neglect, poor self-care
- ❑ Sleep problems
  - ❑ Oversleeping ❑ too little sleep ❑ insomnia ❑ early waking ❑ nightmares

School & Work

- ❑ Academics—performance/study skills
- ❑ Attention, concentration, distractibility
- ❑ Career/job dissatisfaction
- ❑ Career goals and decisions, career transitions
- ❑ Childhood school experiences
- ❑ Employment/Unemployment
- ❑ Failure
- ❑ Procrastination, work inhibitions, motivation challenges
- ❑ Trouble keeping a job
- ❑ Workaholism/overworking

Trauma/Abuse (Past or Present)

- ❑ Childhood abuse or neglect (verbal, emotional, physical, psychological, sexual)
- ❑ Exposure to family violence
- ❑ Exposure to animal cruelty
- ❑ Psychological abuse/torture
- ❑ Relationship/domestic violence
- ❑ Sexual assault/unwanted sex
- ❑ Sexual harassment/exploitation
- ❑ Stalking/cyberstalking victimization
- ❑ War/military conflict exposure
- ❑ Other exposure to violence/abuse/trauma____

Any current crisis situations?____

Any other concerns or issues? ____

---

* If you would find it helpful to write a narrative statement about the concerns that are motivating you to seek treatment at this time, feel free to write on the back of these forms or attach a separate sheet.

Do you take ANY medication on a regular basis for chronic or recurring conditions? (Due to drug interactions, please list all medications.) Are you currently taking or have ever taken any psychotropic medications?

Medicine	Doctor	Reason	Start date

Please look back over the concerns you have checked off and choose the three for which you most want help:

1)

2)

3)

Please estimate the severity of your problems:

❑ mildly upsetting ❑ moderately severe ❑ severe ❑ very severe ❑ incapacitating

Please list your typical strategies for reducing stress:

____

____

____

Finally, please list your greatest strengths:

____

____

____

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CHILD INTAKE FORM

CHILD'S HISTORY

In order for me to serve you better, please answer the following questions and return this form prior to your appointment or you may bring it in with you. Feel free to add any extra comments on a separate sheet. If there are any questions that you cannot or choose not to answer, please leave them blank.

Today's date _______________

Name of child ____ Birth date ____________

School ______________________ Grade ________ Teacher ___________________________

Your name and relationship to child ____
Name of child's legal guardian(s) ____
Who referred you? ____

CONCERNS

What are the main concerns you have about your child?

____
____
____
____

A. How long has this problem been a concern? ____
B. When did you first notice the problem? ____
C. Who else have you seen for this problem? ____
D. What evaluations have already been performed? ____
____
E. What has already been done to treat this problem (diet, medications, counseling)? ___________
____
F. What have you done, personally, to address the problem? _________________________________
____
G. What seems to help the most?____

PREGNANCY AND BIRTH

1. Was the pregnancy a) planned? ❑ Yes ❑ No
   b) welcomed? ❑ Yes ❑ No
   c) stressful? ❑ Yes ❑ No
2. How many weeks into the pregnancy was it diagnosed? ______________________________
3. For the three months prior to the pregnancy and the first two months of pregnancy did the mother use any:
   prescribed medications? ❑ Yes ❑ No How much ______________________
   recreational drugs? ❑ Yes ❑ No How much ______________________
   alcohol? ❑ Yes ❑ No How much ______________________
   tobacco? ❑ Yes ❑ No How much ______________________
4. During the following seven months of pregnancy did the mother use any:
   prescribed medication? ❑ Yes ❑ No How much ______________________
   recreational drugs? ❑ Yes ❑ No How much ______________________

alcohol? ❑ Yes ❑ No How much ______________________________

tobacco? ❑ Yes ❑ No How much ______________________________

5. Where there any medical concerns or other issues during this pregnancy regarding mother and/or baby?____
____
____
6. Please list types of pain medications/anesthesia used during delivery __________________________
7. At the time of birth:
   How long did the pregnancy last? __________weeks
   How long was the labor? __________hours
   What was the baby's birth weight? __________ lbs __________oz, length? __________inches
   head circumference? __________inches
   Was the baby born vaginally __________or caesarean __________?
   Was the baby born head first __________breech __________or other (explain) ______________________
   Did the baby have? (please circle all that apply):

trouble breathing	yellow jaundice	blood transfusion
resuscitation	jitteriness	physical injuries
twin	seizures/fits	trouble sucking
birth defects	cord around neck	intensive care
fevers or low temperature		

8. Was the baby breast fed? _______ How long? _______ Bottle fed? _______Formula name______________
9. Did the baby have any early feeding problem? _______ Describe________________________________
____
10. Were there any other concerns or problems noted by either the doctors or parents? Please describe. ____
11. Is your child adopted? _______Does he/she know? _______If not, do you intend to tell him/her? _________
12. At what age was the child placed in your home? ______At what age was the child adopted? _______

HEALTH

1. Has your child had any of the following? (please circle all that apply):

measles	mumps	chicken pox	whooping cough
pneumonia	encephalitis	meningitis	ear infections
lead poisoning	allergies	vision problems	hearing problems
unexplained high fevers			

   Please explain any you circled____
____
2. Does your child have any of the following? (please circle any that apply):
   A. sleep problems (falling asleep, staying asleep, nightmares, sleepwalking, etc.)
   B. brain disorders (headaches, seizures, motor or vocal tics, tremors, confusion, muscle weakness, coordination difficulties, head injury, staring spells, unexplained anger or sudden and unprovoked emotional outbursts, etc.)
   C. lung problems (shortness of breath, asthma, coughing, etc.)
   D. skin disorders (acne, hair loss, birthmarks, dermatitis, eczema, etc.)
   E. blood disorders (anemia, bleeding bruising, etc.)
   F. heart problems (chest pain, surgery, congenital heart disease, murmur, etc.)
   G. sexual problems (birth control, promiscuity, excessive masturbation, etc.)
   H. kidney problems (bedwetting, infections, etc.)
   I. muscle or bone problems (scoliosis, injuries, strains, spasticity, etc.)
   J. history of poisoning (lead, chemicals, others)
   K. gland problems (obesity, slow or fast growth, early or delayed puberty, thyroid problems, etc.)
   L. stomach or bowel problems (diarrhea, vomiting, constipation, stomach aches, stool soiling, etc)
   M. genetic disorders (birth defects, inherited traits, chromosome abnormalities

   Please explain any of the items which you circled____
____
____

3. Has your child ever been hospitalized? If so, explain each hospitalization, including ages, reasons, and length of stay: ________________

4. Has your child ever taken medication to help with behavior or emotional problems?

Age	Medicine	Doctor	Reason	When/Why stopped?

5. Does your child take ANY medication on a regular basis for chronic or recurring conditions? (Due to drug interactions, please list all medications.)

Medicine	Doctor	Reason	Start date

6. Has your child had any special diagnostic tests (x-rays, EEG, MRI, CT scan, blood tests, etc.)

Age	Test	Reason	Results

7. Have you ever suspected that this child might have been physically or sexually abused?
   ❑ Yes ❑ No If yes, please explain: ________________

DEVELOPMENT

1. Early development
   A. At about what age did your child first:

	Early	On Time	Late
smile, goo and coo?	____	____	____
sit up?	____	____	____
crawl?	____	____	____
stand alone?	____	____	____
speak real words?	____	____	____
walk by self?	____	____	____
feed self?	____	____	____
use two word sentences?	____	____	____
dress self (except buttoning and tying)?	____	____	____
speak so that strangers understood?	____	____	____
ride a tricycle?	____	____	____
ride a bicycle?	____	____	____
tie own shoe?	____	____	____

   B. Do you have any concerns about your child's motor or muscle development? ________________

   C. Do any of the following concern you regarding your child's language development? Please circle:

trouble finding the right word	too few words
unconnected thoughts	repeats words/phrases over and over
has seen a speech therapist	speech clarity
following directions	seems confused when spoken to
stuttering	missing sounds (like **r** or **k**)

   D. Have you ever been concerned or been told that your child's development (speech and language, coordination, growth or social abilities) was behind his/her peers? ________________

____

E. Did your child seem to learn pre-academic skills such as numbers, colors, shapes, etc., at the same time as other children his/her age? If not, please explain:____
____
____

SCHOOL

1. What is your impression of your child's learning potential? Please circle:
   low   average   above average   gifted
2. Do you feel that your child is performing up to his/her potential in school? ❑ Yes ❑ No
3. Do you feel that your child has any difficulties with (circle any that apply and explain):
   reading____
   writing____
   arithmetic____
   social studies____
   science____
   languages____
4. Is homework a problem? If so, please circle all that apply:

can't get started	no place to work
forgets to bring home materials	forgets assignments
doesn't understand the work	doesn't anticipate deadlines
distracted by radio, TV or anything	takes too long
battles or argues about doing work	the most stressful time of day
needs you there constantly	doesn't care/no motivation

5. Is your child's work made more difficult by problems with:

	Not at all	Somewhat	A lot
poor concentration	__________	__________	__________
giving up too easily	__________	__________	__________
inconsistent performance	__________	__________	__________
poor motivation	__________	__________	__________
disorganization	__________	__________	__________
spacing out or daydreaming	__________	__________	__________
not finishing things	__________	__________	__________
having low frustration tolerance	__________	__________	__________
anxiety/sadness	__________	__________	__________
poor handwriting	__________	__________	__________
rapidly shifting from one thing to another	__________	__________	__________
being easily distracted	__________	__________	__________
impulsiveness	__________	__________	__________
anxious	__________	__________	__________

6. Has your child ever been retained ________suspended ________expelled ________advanced a grade________?

SOCIAL

Does your child get along well with others? In what areas do you notice difficulties? Please answer yes, no or sometimes to the following. You may add comments.

makes friends easily____
has a best friend____
plays well with others ____
shares easily____
follows rules____
enjoys team sports____
leads other children____
helps others____
easily influenced____
prefers to be alone____

is a party animal ______________________________
bullies others ______________________________
fights others ______________________________
insists on having his own way ______________________________

SELF-ESTEEM

Does your child:

- have an "I can do it" attitude? ❑ Yes ❑ No
- recover from upsets? ❑ Yes ❑ No
- recognize strengths? ❑ Yes ❑ No
- give up easily? ❑ Yes ❑ No
- stand up for self? ❑ Yes ❑ No
- lack confidence? ❑ Yes ❑ No
- act adventuresome? ❑ Yes ❑ No

FAMILY

1. Are you satisfied with how your family works? Please circle any that might apply:
   - lack of structure; rules
   - poor communication
   - poor division of chores, responsibilities
   - marital problems
   - no family "together times"
   - financial troubles
   - lack of "breathing space"
   - resentment of another member

   Comments: ______________________________
   ____
   ____

2. Where and how does this child fit in the family? Please circle any that apply:
   - sibling rivalry (more than expected)
   - spoiled, always gets own way
   - a rescuer, can't stand upsets
   - a team player
   - a manipulator
   - a helper

   Born baby #__________ out of __________children.

3. What types of discipline are used in your family? Use **M** to indicate which ones mother uses, **F** to indicate which ones father uses:
   - discussion and education __________
   - encouraging independent thinking__________
   - contracts/token systems __________
   - lecturing, nagging, yelling__________
   - positive reward and praise__________
   - time out__________
   - spanking__________
   - restriction/grounding__________

   For what is your child most frequently disciplined? ______________________________
   ____
   What type of discipline(s) work best with your child? ______________________________
   ____

4. Please circle any of the following stressors which might apply to your family's situation, or to which the child had an extremely strong reaction. Please note how long ago the stressor occurred:
   - parental separation/divorce
   - death of a family member/important friend
   - change in school
   - financial stress
   - severe illness
   - move to a new house
   - change of job
   - pregnancy/birth of new child

   Comments______________________________
   ____

5. Are there any "family secrets" or important things I have left out? Please include such things as relationships between divorced parents, involvement of extended family, parental adjustment difficulties, etc.:
   ____
   ____
   ____
   ____

6. Please circle current marital status: married single divorced widowed live together

7. If divorced from biological parent, what are the custody arrangements (legal <u>and</u> physical, please)?
   ____
   ____
   ____

8. If divorced, what is the non-custodial parent's involvement with this evaluation? ______________________________
____
9. What are the names and ages and relationship of other children living at the home? ___________
____
10. Is there any family history of medical, developmental, learning, psychiatric, or legal difficulties?
❑ Yes ❑ No If yes, please list the individual's relationship to the child, the nature of each difficulty, and any treatments received. Please include past generations and extended family if you have such information:
____
____
____
____
11. Please describe any psychiatric or psychological treatment this child or any sibling has received:
____
____
____
____
12. Please review each of the following lists of characteristics and check any item that applies to your child:

A. Does your child have any of the following attention related troubles?

_____fidgets
_____easily distracted
_____difficulty playing quietly
_____shifts from one activity to another
_____often interrupts or intrudes on others
_____often engages in physically dangerous activities
_____often blurts out answers to questions before completed
_____difficulty remaining seated
_____difficulty awaiting turn
_____difficulty sustaining attention
_____often does not listen
_____often loses things
_____difficulty following instructions
_____often talks excessively

B. Does your child have any of the following oppositional troubles?

_____often deliberately acts to annoy others
_____is often touchy or annoyed by others
_____often swears/uses obscene language
_____often blames others for own mistakes
_____often actively defies or refuses adult requests of rules
_____often takes or touches others' property without asking
_____often agues with adults
_____is often angry or resentful
_____is often spiteful or vindictive
_____often loses temper

C. Has your child had problems with any of the following?

_____stolen without confrontation
_____deliberate fire setting
_____breaking and entering
_____cruel to animals
_____forced someone else into sexual activity
_____often initiates physical fights
_____lies often
_____often truant from school
_____destroyed others' property
_____used a weapon in a fight
_____stolen with confrontation
_____physically cruel to people

D. Does your child show any of the following anxiety symptoms?

_____unrealistic worry about future events
_____persistent refusal to go to school
_____bothersome thoughts
_____unrealistic concerns about competence
_____repeated nightmares about separation from you
_____ongoing refusal to sleep alone
_____excessive distress when separated from home or from you
_____excessive need for reassurance
_____unrealistic and persistent worry that something will happen to you
_____avoidance of being alone
_____physical aches and pains
_____marked self consciousness
_____marked inability to relax

E. Does your child show:

_____diminished pleasure in activities
_____depressed or irritable mood most of the day, nearly every day
_____poor appetite or overeating
_____trouble sleeping or sleeping too much
_____feelings of worthlessness or excessive inappropriate guilt
_____suicidal thoughts or actions
_____ agitation or sluggishness
_____ low self esteem

_____poor concentration or difficulty making decisions _____ low energy or fatigue
_____ feelings of hopelessness

F. Does your child have any of the following?

_____repeated unusual movements _____odd postures
_____compulsive rituals _____motor tics
_____vocal tics _____overreacts to touch
_____excessive reaction to noise or failing to react to loud noises

G. Has your child exhibited any symptoms of thought disturbance, including any of the following?

_____can't get to the point, loses train of thought
_____bizarre ideas (odd fascinations, strange ideas, hallucinations)
_____disoriented, confused, staring or "spacey"
_____incoherent speech (mumbles, uses words only the child understands)

H. Has your child exhibited symptoms of affective mood disturbance, including any of these?

_____explosive temper with little provocation _____unusual fears
_____excessively monotonous or bland affect _____panic attacks
_____situationally inappropriate emotions _____excessive mood swings
_____excessive reaction to changes in routine

Comments regarding any of the above items that you checked:____
____
____
____

STRENGTHS

Please tell me about your child's most outstanding characteristics, hobbies, achievements, abilities, etc.:
____
____
____
____

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