Adult Intake Form

Last Name **First** **Middle**

Date of Birth: _____ Home Phone: _____
Cell Phone: _____ E-mail: _____
Occupation: _____ Employer: _____
Marital Status: _____

Home address: _____

Emergency Contact
(Name & Phone number) **:**

Referred by:
Primary Care Doctor:
Therapist:

Reason you are seeking treatment: _____
What are your treatment goals?

Your Psychiatric & Medical History

Current Weight _____ Height _____ Allergies: _____

Current Medical Problems: Past Medical Problems & Surgeries:

List ALL current prescription medications and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date

Current over-the-counter medications or supplements:

Date and place of last physical exam:_____
Exercise:
Do you exercise regularly? ( ) Yes ( ) No

Sleep:
Do you have difficulty falling asleep?_____
Awakenings during the night?_____
Poor or unrefreshing sleep?_____
If so, how long have you been experiencing this problem for? (duration) _____
How many times per week do you experience this?(frequency) _____

Eating Habits:
Do you spend a lot of time thinking about and trying to lose weight?
Do you often feel out of control when eating?
Do you ever make yourself engage in risky behavior (e.g., fasting, over-exercising, vomiting, laxative use, taking diet pills) in order to avoid gaining weight or maintain your current weight?
Do you eat large amounts of food when you are not hungry?

Substances:
How much caffeine do you drink every day?
How much alcohol do you drink every week?
Do you use marijuana?

For women:
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Personal and Family Medical & Psychiatric History

	You	Your Mother	Your Father	Your Sibling(s)	Aunts/ Uncles/ Cousins
Anemia					
Anxiety					
Autism					
Asthma					
Bipolar Disorder					
Cancer					
Chronic Fatigue					
Chronic pain					
Depression					
Diabetes					
Seizures					
Fibromalgia					
Heart Disease					
Head Trauma					
Liver disease					
Post-traumatic Stress disorder					
Schizophrenia					
Stomach problems					
Substance Use (including alcoholism)					
Suicide attempt					
Other:					

Past Psychiatric Medications:

Have you ever been hospitalized for psychiatric reasons? If so when and for how long?
_____
Have you ever attempted suicide?_____Have you ever engaged in cutting behaviors?_____