

Adult Intake Form

Patient's Name:		DOB:		Age:	
Religion:		Race:		Marital Status:	
Address:		City/ST:		No. of children:	
		Zip:		County:	
With whom are you currently living:					
Referral Source:		Phone:		Fax:	

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems/symptoms):

How long have the above symptoms occurred?

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY
 (Please include contact with other professionals, medications, types of treatment, etc.)

Date:	Type of Treatment:	Medications:	Currently taking?	Effective?
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

PRIOR DIAGNOSES:

MEDICAL HISTORY

Past/current medical conditions:

Currently being treated? Y N

Medications/vitamins/herbs:

Hospitalizations:

Date:	Cause:
Date:	cause:

NEUROPSYCHIATRIC HISTORY

Any history of head trauma, concussion, strokes or significant accidents? (describe):

Date:	Type of Accident/Diagnosis:	Hospitalization/Treatment?	Rehabilitation? Where?
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

History of seizures or seizure like activity? Y N Date seizures began:

Prior abnormal lab tests, X-rays, EEG, MRI, etc: Y N Date tests conducted:

Please bring pertinent medical records; lab results, MRI report, psychological testing, etc.

DEVELOPMENTAL HISTORY

Months gestation?	Complications? <input type="checkbox"/> Y <input type="checkbox"/> N List: _____	Hours mom in labor:
Vaginal or Cesarean birth (circle one)	Estimated birth weight:	
Milestones (walk, talk, etc.) reached on time? <input type="checkbox"/> Y <input type="checkbox"/> N List if no: _____		
FAMILY HISTORY		
No. of siblings in your childhood family?		Which number are you?
<u>Father's side</u>		<u>Mother's side</u>
Schizophrenia/psychosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Schizophrenia/psychosis <input type="checkbox"/> Y <input type="checkbox"/> N
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression <input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety Disorder/OCD	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety Disorder/OCD <input type="checkbox"/> Y <input type="checkbox"/> N
Bipolar Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Bipolar Disorder <input type="checkbox"/> Y <input type="checkbox"/> N
Personality Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Personality Disorder <input type="checkbox"/> Y <input type="checkbox"/> N
Substance Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	Substance Abuse <input type="checkbox"/> Y <input type="checkbox"/> N
Mental Retardation/LD	<input type="checkbox"/> Y <input type="checkbox"/> N	Mental Retardation/LD <input type="checkbox"/> Y <input type="checkbox"/> N
Autism/Asperger's/PDD	<input type="checkbox"/> Y <input type="checkbox"/> N	Autism/Asperger's/PDD <input type="checkbox"/> Y <input type="checkbox"/> N
Eating Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Eating Disorder <input type="checkbox"/> Y <input type="checkbox"/> N
History of abuse/neglect	<input type="checkbox"/> Y <input type="checkbox"/> N	History of abuse/neglect <input type="checkbox"/> Y <input type="checkbox"/> N
Genetic Medical Condition	<input type="checkbox"/> Y <input type="checkbox"/> N	Genetic Medical Condition <input type="checkbox"/> Y <input type="checkbox"/> N
Other _____		Other _____
Dad deceased? <input type="checkbox"/> Y <input type="checkbox"/> N	Cause? _____	Mom deceased? <input type="checkbox"/> Y <input type="checkbox"/> N Cause? _____
PSYCHOSOCIAL HISTORY		
Number of marriages?	Number of biological children?	Number of stepchildren?
History of substance abuse? <input type="checkbox"/> Y <input type="checkbox"/> N	Age abuse began?	Years sober or longest attempt at sobriety?
Drug of choice:	Treatment received? <input type="checkbox"/> Y <input type="checkbox"/> N	Inpatient or Outpatient (circle applicable)
Problems with sleeping? <input type="checkbox"/> Y <input type="checkbox"/> N	Explain:	
Problems with eating? <input type="checkbox"/> Y <input type="checkbox"/> N	Explain:	
Number of incarcerations:	Charges:	Years served:
Other contact with the legal system: <input type="checkbox"/> Y <input type="checkbox"/> N Explain:		
Currently employed? <input type="checkbox"/> Y <input type="checkbox"/> N	Years on job:	Longest time employed:
Military service? <input type="checkbox"/> Y <input type="checkbox"/> N	Branch:	Years of service:
History of physical/sexual abuse?	Age abuse began:	Treatment received? <input type="checkbox"/> Y <input type="checkbox"/> N
History of mental abuse/neglect?	Age abuse began:	Treatment received? <input type="checkbox"/> Y <input type="checkbox"/> N
Personal strengths:		Personal weaknesses:
Current life stresses:		
Explain coping strategies:		
EDUCATIONAL HISTORY		
Last grade completed:	Highest degree awarded:	Training/specialty:
Special education: <input type="checkbox"/> Y <input type="checkbox"/> N	Gifted classes? <input type="checkbox"/> Y <input type="checkbox"/> N	Behavior problems? <input type="checkbox"/> Y <input type="checkbox"/> N Retained? <input type="checkbox"/> Y <input type="checkbox"/> N
Other problems in school? <input type="checkbox"/> Y <input type="checkbox"/> N	Explain:	
Average grades or g.p.a.:	Academic/achievement testing performed in school? <input type="checkbox"/> Y <input type="checkbox"/> N	