Adult Intake Form

Patient's Name ____ DOB _________________

Primary Care Physician ______________________________ Therapist _________________________

Current Symptoms Checklist:

☐ Depressed mood ☐ Racing thoughts ☐ Excessive worry ☐ Unable to enjoy activities ☐ Impulsivity ☐ Anxiety attacks ☐ Sleep pattern disturbance ☐ Increase risky behavior ☐ Avoidance ☐ Loss of interest ☐ Hallucinations ☐ Concentration/forgetfulness ☐ Decrease need for sleep ☐ Change in appetite ☐ Excessive energy ☐ Excessive guilt ☐ Increased irritability ☐ Fatigue ☐ Crying spells ☐ Other_______________

Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

Do you currently feel that you don't want to live? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? ☐ Yes ☐ No

Current Medications:

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Reason

Current over-the-counter medications or supplements:

____

____

____

____

____

Past Psychiatric History

Have you ever participated in outpatient treatment? ☐ Yes ☐ No. If yes, Please describe when, by whom, and nature of treatment.

___

___

___

___

Do you have a history of past psychiatric hospitalization? ☐ Yes ☐ No. If yes, describe for what reason, when and where.

___

___

___

___

Past Psychiatric Medications:

Antidepressants: ___

Antipsychotics: ___

Mood Stabilizers: ___

Sedative/Hypnotics: ___

ADHD Medications: ___

Antianxiety medications: ___

Other: ___

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ☐ Yes ☐ No

Schizophrenia ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Post-traumatic stress ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Alcohol/Substance abuse ☐ Yes ☐No

Anger ☐Yes ☐ No

Suicide ☐ Yes ☐ No

Violence ☐ Yes ☐ No

If yes, who had what problems?

___

___

___

Occupational History:

Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Student

What is/was your occupation? ____

Where do you work? ____

Have you ever served in the military? ☐ Yes ☐ No

Relationship History and Current Family:

Are you currently: ☐ Married ☐Divorced ☐ Single ☐ Widowed ☐Partnered

How long? _____

If not married, are you currently in a relationship? ☐ Yes ☐ No

If yes, how long? ___________________

Describe your relationship with your spouse or significant other:

____

____

Have you had any prior marriages? ☐Yes ☐No

Do you have children? ☐Yes ☐No

Describe your relationship with your children:

____

____