Adult Intake Form

Please Print Clearly

Client's First Name _____ Last Name _____ MI_____ Date _____

Address: _____ City _____ State _____ Zip _____

Primary Contact Phone #_____ May we leave a message and send automated text reminders YES or NO

Secondary Phone #_____ May we leave message: YES or NO

Birth Date _____ Age_____ Gender_____ Email_____

Client's Soc. Sec. #_____

Martial Status: (Circle One) Single, Living with Partner, Married, Separated, Divorced, Widowed.

Length of Relationship:_____ Satisfaction with current relationship: ☐ Satisfied ☐Somewhat unsatisfied ☐Unsatisfied

Spouse/Partner's Name: _____ Phone: _____

Children's names/ages: _____

_____

Others living in your home: _____

Insurance Information (Please have your insurance card and Driver's license available for your file)

Primary Insurance: _____

Policy ID #_____

Group #_____

Subscriber: _____

Subscribers Date of Birth:_____

Patient's relationship to Subscriber: (Circle one) Self, Spouse, Child, Other

Health Information:

Primary Care Physician: _____ Phone_____

Date of last visit:_____ Would you like for me to work with your primary care physician? Y or N

If Yes, please initial for consent to speak with your physician

Initials: _____ By initialing here I consent for Trina Fry, LCPC to coordinate care with my primary care physician if necessary for the best care and treatment for my Mental Health.

Are you taking any medication or homeopathic treatments? Yes or No (circle one)

Allergies_____

Name of current meds	Dosage	Frequency	Purpose	Prescribing Doctor

Current Concerns: Check the areas that apply

- ☐ Depression
- ☐ Anxiety/Stress
- ☐ Relationships
- ☐ Eating issues
- ☐ Life Transitions
- ☐ Substance abuse
- ☐ Divorce
- ☐ Career/School
- ☐ Sexuality
- ☐ Grief
- ☐ Anger
- ☐ Abuse
- ☐ Family
- ☐ Parenting
- ☐ Spiritual issues
- ☐ Trauma
- ☐ Finances
- ☐ Health
- ☐ Insecurity
- ☐ Homicidal thoughts
- ☐ Suicidal thoughts

Do you presently feel suicidal or homicidal? ☐Yes ☐No Explain: _____

Have you ever seriously contemplated suicide? ☐Yes ☐No

If yes, have you ever made a suicide attempt? ☐Yes ☐No When? Means (how)?

Do you drink alcohol? ☐Yes ☐No How many drinks do you have a week? _____

Check if you have ever tried the following: If yes, how long and when did you last use:

Marijuana	☐Yes ☐No	
Methamphetamine	☐Yes ☐No	
Cocaine	☐Yes ☐No	
Heroin	☐Yes ☐No	
Stimulants (pills)	☐Yes ☐No	
Pain killers (not as prescribed)	☐Yes ☐No	
Methadone	☐Yes ☐No	
Tranquilizer/sleeping pills	☐Yes ☐No	
Ecstasy	☐Yes ☐No	
LSD/Hallucinogens	☐Yes ☐No	

Spirituality:

Do you practice a faith or religion Yes or No If Yes, please identify: _____

Would you want faith to be a part of Treatment? Yes or No

Symptom Questionnaire

Name: _____ Date: _____

For the questions below, select one option for each question that comes closest to your answer.

OVER THE PAST *TWO WEEKS*, HAVE YOU:	**Not At All**	**1-2 Days**	**3-5 Days**	**Daily**
Experienced sadness, weepiness, or crying spells.	☐	☐	☐	☐
Felt hopeless, pessimistic or discouraged about the future.	☐	☐	☐	☐
Not been able to enjoy things?	☐	☐	☐	☐
Felt tired, slowed down, or had no energy?	☐	☐	☐	☐
Lacked motivation or interest in doing things?	☐	☐	☐	☐
Had difficulty falling asleep or frequent waking/sleeping too much?	☐	☐	☐	☐
Had difficulty making decisions or concentrating?	☐	☐	☐	☐
Experienced increased/decreased appetite?	☐	☐	☐	☐
Felt guilty or worthless?	☐	☐	☐	☐
Felt like you wanted to die, or wished you were dead?	☐	☐	☐	☐
Seriously considered or planned to end your own life?	☐	☐	☐	☐
Felt restless, worried, or nervous?	☐	☐	☐	☐
Had headaches, stomachaches or pain?	☐	☐	☐	☐
How much distress would you say these symptoms caused you? ☐**Mild** ☐**Moderate** ☐**Severe**				

IN YOUR LIFETIME HAVE YOU EVER HAD A *WEEK* WHERE YOU:	**Yes**	**No**
Felt excessive energy to the point of being hyper, overexcited, or giddy?	☐	☐
Had an unusually high or good mood that was uncharacteristic of you?	☐	☐
Felt like your mind was flooded with ideas and your thoughts were racing?	☐	☐
Did not need as much sleep as you normally do?	☐	☐
Acted impulsively by participating in risky or irresponsible behavior (increased shopping, sex, drugs, alcohol)?	☐	☐
Felt more interest in exciting, pleasurable activities than you usually do?	☐	☐
Felt more outgoing, rowdy, or socially open than you regularly do?	☐	☐
Found yourself easily distracted by things going on around you?	☐	☐

DURING THE PAST SIX *MONTHS* HAVE YOU EXPERIENCED THE FOLLOWING *THREE OR MORE* TIMES PER WEEK?	**Yes**	**No**
Felt nervous and anxious about things at work, home, or school?	☐	☐
Had difficulty controlling worries or fears?	☐	☐
Felt restless, nervous, or on edge?	☐	☐
Felt tired, exhausted, or easily worn out?	☐	☐
Had difficulty concentrating?	☐	☐
Felt easily annoyed, irritated or frustrated?	☐	☐
Had difficulty with tense or tight muscles?	☐	☐
Had trouble falling asleep or woke frequently throughout the night?	☐	☐
Had others notice that you worry or been told that you worry too much?	☐	☐
How much distress would you say these symptoms cause you? ☐**Mild** ☐**Mild-Moderate** ☐**Moderate** ☐**Moderate-Severe**		

HAVE YOU EVER EXPERIENCED A MOMENT IN TIME WHEN YOU FELT INTENSE FEAR AND DISTRESS AND EXPERIENCED AT LEAST THREE OF THE FOLLOWING SYMPTOMS?	Yes	No
Shaking or trembling?	☐	☐
Intense sweating?	☐	☐
Loss of breath or shallow breathing?	☐	☐
Feeling dizzy or out of control?	☐	☐
Chills or hot flashes	☐	☐
Rapid heartbeat?	☐	☐
Nausea?	☐	☐
Fear of dying?	☐	☐
How much distress would you say these experiences caused you? ☐**Mild** ☐**Mild-Moderate** ☐**Moderate** ☐**Moderate-Severe**		

HAVE YOU EVER EXPERIENCED OR WITNESSED ANY OF THE FOLLOWING TRAUMATIC EVENTS?	Yes	No
Natural disaster (flood, hurricane, tornado, earthquake, fire, industrial accident?	☐	☐
Transportation accident (car, boat, train, or plane)?	☐	☐
Physical assault as a child?	☐	☐
Physical assault as an adult?	☐	☐
Sexual assault/abuse as a child?	☐	☐
Sexual assault as an adult?	☐	☐
Combat, exposure to a war-zone, or captivity?	☐	☐
Life threatening illness?	☐	☐
Sudden, unexpected death or injury of someone close to you?	☐	☐
Serious injury, harm, or death to someone else you caused or witnessed?	☐	☐
Experienced re-occurring and unwanted flashbacks, nightmares or reminders of the event?	☐	☐
Made efforts to avoid thinking or talking about this event, or doing thing that remind you of it?	☐	☐
Felt less interest in people and things, a feeling of numbness, or trouble experiencing emotions?	☐	☐
Felt nervous, jumpy, or had a sense of heightened alertness?	☐	☐
Had trouble with irritability, falling or staying asleep, or with concentrating?	☐	☐

SELF-HARM	
Have you ever cut yourself or hurt yourself intentionally:	☐**Yes** ☐**No** **If Yes, Describe:**

GIVEN THE LIST OF CATEGORIES BELOW, HOW MUCH STRESS IS EACH CAUSING YOU?				
	None	Mild Stress	Moderate Stress	Severe Stress
Health (include sleep and appetite)	☐	☐	☐	☐
Education/Employment	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Day to Day Tasks	☐	☐	☐	☐
Finances	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Family/Significant Relationships	☐	☐	☐	☐
Legal System	☐	☐	☐	☐