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Psychology Candidate

Boulder, CO
720-204-8540

Adult Intake Form

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session.

Name: ____
(Last) (First) (MI)

Today's Date ____/____/________ Your Birth Date: _____ /_____ /_________ Age: ______

Gender: □ Male □ Female □ Transgender

Local Address:

____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: _________________________ May I leave a message? □Yes □No

Cell Phone: ___________________________ May I leave a message? □Yes □No

E-mail: _____________________________________ May I email you? □Yes □No
*Please be aware that email might not be confidential.

Person to contact in case of an emergency:

_____________________________ ________________ __________________
(Name) (Relationship to client) (Phone)

Primary Care doctor:_____________________ _________________________________
(Name) (Phone)

How did you learn about me?: ____

What prompted you to seek therapy or an assessment?

Sexual Preference: Men Women Both

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □Yes □No

If yes, for how long?_________________

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If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship? ______

Do you have children? □No □Yes

If yes, how many?: _____ Ages: ___________________________

Have you had previous psychotherapy? □No □Yes

If yes, why?____

If yes, when?____

Are you currently taking prescribed psychiatric medications (antidepressants or others)? □Yes □No

If Yes, please list names and doses: ____

If No, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list names and dates: ____

Are you hopeful about your future? □Yes □No

Are you having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

If yes, have you recently done anything to hurt yourself? □Yes □No

Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never", when did you have these thoughts?____

Did you ever act on them? □Yes □No

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? □Yes □No

Have you previously had homicidal thoughts? □Yes □No

If yes, when?____

HEALTH INFORMATION

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Date of last physical examination _________________________

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

____

Any Allergies? □ No □ Yes If yes, please list:____

Medications:____

Hours per night you normally sleep _______

Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Can't fall asleep □ Can't stay asleep

Do you exercise regularly? □ No □ Yes

If yes, how many times per week do you exercise? ______ For how long? ______________

If yes, what do you do?____

Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Do you regularly use alcohol? □ No □ Yes

If yes, what is your frequency?

□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

If you checked any box other than "never," which drugs do you use?
____

Do you smoke? □ No □ Yes

If yes, how many cigarettes per day?________________

Do you drink caffeinated drinks? □ No □ Yes

If yes, # of sodas per day______ cups of coffee per day_______

Have you ever had a head injury? □ No □ Yes

If yes, when and what happened?____

In the last year, have you experienced any significant life changes or stressors?

____

____

*Note: use rating scale with a "yes" response only.

Are you now experiencing:			*Rating Scale 1-10 (10 =worst)
Depressed Mood or Sadness	yes	no	______
Irritability/Anger	yes	no	______
Mood Swings	yes	no	______
Rapid Speech	yes	no	______
Racing Thoughts	yes	no	______
Anxiety	yes	no	______
Constant Worry	yes	no	______
Panic Attacks	yes	no	______
Phobias	yes	no	______
Sleep Disturbances	yes	no	______
Hallucinations	yes	no	______
Paranoia	yes	no	______
Poor Concentration	yes	no	______
Alcohol/Substance Abuse	yes	no	______
Frequent Body Complaints (e.g., headaches)	yes	no	______
Eating Disorder	yes	no	______
Body Image Problems	yes	no	______
Repetitive Thoughts (e.g., Obsessions)	yes	no	______
Repetitive Behaviors (e.g., counting)	yes	no	______
Poor Impulse Control (e.g., ↑ spending)	yes	no	______
Self Mutilation	yes	no	______
Sexual Abuse	yes	no	______
Physical Abuse	yes	no	______
Emotional Abuse	yes	no	______

Have you experienced in the past:			*Rating Scale 1-10 (10 =worst)
Depressed Mood or Sadness	yes	no	______
Irritability/Anger	yes	no	______
Mood Swings	yes	no	______
Rapid Speech	yes	no	______
Racing Thoughts	yes	no	______
Anxiety	yes	no	______
Constant Worry	yes	no	______
Panic Attacks	yes	no	______
Phobias	yes	no	______
Sleep Disturbances	yes	no	______
Hallucinations	yes	no	______
Paranoia	yes	no	______
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Frequent Body Complaints (e.g., headaches)	yes	no	______
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Body Image Problems	yes	no	______
Repetitive Thoughts (e.g., Obsessions)	yes	no	______
Repetitive Behaviors (e.g., counting)	yes	no	______
Poor Impulse Control (e.g., ↑ spending)	yes	no	______
Self Mutilation	yes	no	______
Sexual Abuse	yes	no	______
Physical Abuse	yes	no	______

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Emotional Abuse yes no ______

OCCUPATIONAL, EDUCATIONAL, LEGAL INFORMATION:

Are you employed? □ No □ Yes

If yes, who is your current employer/position? ___________________________________

If yes, are you happy at your current position? ___________________________________

Please list any work-related stressors, if any: ____________________________________

Do you have financial concerns? □ No □ Yes

If yes, please explain: ____

Are you currently in the military? □ No □ Yes Previously? □ No □ Yes

Highest level of education:____

Do you have any legal concerns? □ No □ Yes

If yes, please explain:____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? ____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY HISTORY:

Are your parents: □ still together
□ divorced, when____________
□ remarried
□ unmarried
□ deceased, if yes whom_________________ age at death______

Number of siblings:_______ Ages:______________________________

Do you have good family support? □ No □ Yes From whom?___________________________

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		Family Member(s)
Depression	yes/no	____________________________
Bipolar Disorder	yes/no	____________________________
Anxiety Disorders	yes/no	____________________________
Panic Attacks	yes/no	____________________________

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Schizophrenia	yes/no	______________________________
Alcohol/Substance Abuse	yes/no	______________________________
Eating Disorders	yes/no	______________________________
Learning Disabilities	yes/no	______________________________
Trauma History	yes/no	______________________________
Suicide Attempts	yes/no	______________________________
Psychiatric Hospitalizations	yes/no	______________________________

OTHER INFORMATION:

Are you satisfied with your social situation/interpersonal relationships? □ No □ Yes

If no, explain why:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies you use when stressed?

What are your overall goals for therapy?

What do you feel you need work on first?