

# ADULT INTAKE FORM

Today's Date: \_\_\_\_\_

<b>Name:</b> (First) (M.I.) (Last)	<b>Birth date:</b>	<b>Age:</b>
<b>Relationship Status:</b>	<b>Gender Identification</b> Male Female Other	
<b>In Case of Emergency, please contact:</b>	<b>Phone:</b>	<b>Relationship:</b>

Please give a brief description of why you are seeking treatment: \_\_\_\_\_  
\_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

## **FAMILY HISTORY**

Your Parent's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Education level: \_\_\_\_\_

Your Parent's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Education level: \_\_\_\_\_

Do you have a guardian? Yes/no Contact info for guardian or parent: \_\_\_\_\_

Your Sibling(s): Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Were you adopted? Yes No

Has there been any abuse in your history? None Physical Verbal/Emotional Sexual

Describe any *family history* of mental health or chemical dependency problems or treatment: \_\_\_\_\_  
\_\_\_\_\_

List any involvement with social services, court system or legal services: \_\_\_\_\_

If applicable, your spouse/partner's name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

If applicable, list name, ages, and sex of each of your children: \_\_\_\_\_

If applicable give date(s) of your marriage, separation(s) and/or divorce: \_\_\_\_\_

List current members of your household: \_\_\_\_\_

## **EDUCATION AND WORK HISTORY**

Education (highest level obtained): \_\_\_\_\_ Current Employer: \_\_\_\_\_

How long employed there? \_\_\_\_\_ Occupation: \_\_\_\_\_

If you have been in the military, please list dates, rank and type of discharge: \_\_\_\_\_  
\_\_\_\_\_

## **CHEMICAL USE HISTORY**

Do you use tobacco products? Yes No If yes, type \_\_\_\_\_ quantity per day \_\_\_\_\_

Do you drink caffeine? Yes No If yes, type \_\_\_\_\_ quantity per day \_\_\_\_\_

Do you drink alcohol? Yes No If yes, usual number of drinks per day \_\_\_\_\_

Usual number of drinks per week \_\_\_\_\_

Please check any that are true for you    In the past month    Within last 12 months    Have used in past    Never

**Cannabis-** Marijuana, Hash

**Amphetamines-** Speed, Cocaine, Crack, Crank, Meth, Dexedrine, White Crosses, Ritalin, Cylert, etc.

**Tranquilizers-** Valium, Xanax, Ativan, Librium, Sleeping Pills, Seconal, Quaaludes, etc.

**Narcotics-** Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.

**Other-** Inhalants, PCP, LSD, Mushrooms, Paint Thinner, Glue, Nitrite "Poppers", etc.

Have you ever felt you ought to cut down on your drinking or drug use?	Yes	No
Have you ever had people annoy you by criticizing your drinking or drug use?	Yes	No
Have you ever felt bad or guilty about your drinking or drug use?	Yes	No
Have you ever had to drink or use drugs as an "eye opener" first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?	Yes	No

**PREVIOUS TREATMENT**

List any psychological/psychiatric treatment you have had:

\_\_\_\_\_

\_\_\_\_\_

List dates of any psychiatric hospitalizations you have had:

\_\_\_\_\_

\_\_\_\_\_

List dates of any treatment for chemical dependency you have had:

\_\_\_\_\_

\_\_\_\_\_

Have you or any other member of your family ever been seen for services through BHSI?    Yes    No

If so, who and when? \_\_\_\_\_

**MEDICAL HISTORY**

Primary Care Clinic: \_\_\_\_\_ Physician: \_\_\_\_\_

Date of last physical? \_\_\_\_\_ Drug Allergies? \_\_\_\_\_

Describe any current medical conditions: \_\_\_\_\_

Describe any past medical conditions including surgeries: \_\_\_\_\_

List any history of head injury, including concussion or loss of consciousness: \_\_\_\_\_

**For this next segment, please note that we are asking for current and past medications:**

Please list any current medications you are prescribed, as well as supplements or consistent use of over the counter medications:

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Are there any medications you are prescribed, but that you are not taking? If so, please list the reason you are not taking the medication (e.g. side effects, cost)

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Please list any previous medications you have taken to help in managing your moods or behaviors:

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**Please check the boxes  of all other problems that you've had during *this last month*. Then, on the line that follows each problem tell us when you first noticed these problems.**

- Fears of crowds or having to talk to people \_\_\_\_\_
- Feeling panic, heart pounding, feel like I'm losing it, I can't stand it \_\_\_\_\_
- Can't get to sleep, or stay asleep \_\_\_\_\_
- Sudden horrible memories or bad nightmares \_\_\_\_\_
- Feeling that I have to do or think something over and over \_\_\_\_\_
- Worrying a lot about germs, diseases, my health \_\_\_\_\_
- Wanting to get revenge or hurt other people \_\_\_\_\_
- Thoughts racing faster than I can follow them \_\_\_\_\_
- Very extreme happiness or ambition \_\_\_\_\_
- Hearing voices in my head or other strange experiences \_\_\_\_\_
- Feeling like people are following me, monitoring me, or plotting to hurt me somehow \_\_\_\_\_
- Out of control spending or gambling \_\_\_\_\_
- Using drugs or drinking too much \_\_\_\_\_
- Out of control eating \_\_\_\_\_
- Dieting too much, or using laxatives or vomiting to lose weight \_\_\_\_\_
- Concerns about sex \_\_\_\_\_
- Frequent headaches, loss of balance, numbness, or sudden vomiting (circle which ones) \_\_\_\_\_
- Frequent, constant, and/or extreme pain \_\_\_\_\_
- Other problems: \_\_\_\_\_

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless – moving around a lot	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

For items 1-9, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all  
 Somewhat difficult  
 Very difficult  
 Extremely difficult

For items 1-9, when did you first notice these problems? \_\_\_\_\_

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

For items 1-7, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all  
 Somewhat difficult  
 Very difficult  
 Extremely difficult