ADULT INTAKE FORM

General Information

Assessment Date:

Revision Date

Full Legal Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

DOB: Age: ______________________________

Martial status:

☐ Single ☐ Married ☐ Divorced

Are you a parent? If so how many children do you have?

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Client's Expectations from Treatment:

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MENTAL HEALTH EXAMINATION:

Appearance:

☐ Appropriate ☐ Bizarre ☐ Disheveled ☐ Neat ☐ Unkempt

Other (specify): ______________________________

Behavior:

☐ Appropriate	☐ Slumped	☐ Rigid	☐ Tense
☐ Decreased Expression	☐ Accelerated Expression	☐ Psycho-motor Retardation	☐ Restless
☐ Loud	☐ Soft Spoken	☐ Domineering	☐ Submissive
☐ Provocative	☐ Suspicious	☐ Uncooperative	

☐ Other (specify):

Mood:

☐ No Impairment	☐ Apprehensive	☐ Angry	☐ Anxious
☐ Blunted	☐ Depressed	☐ Elated	☐ Fearful
☐ Hopeless	☐ Hostile	☐ Inappropriate	☐ Labile
☐ Mood Swings	☐ Sad		

☐ Other (specify):

Perception:

☐ No Impairment	☐ Auditory Hallucinations	☐ Delusions	☐ Distorted Thinking
☐ Grandiosity	☐ Magical Thinking	☐ Paranoia	☐ Visual Hallucinations

☐ Other type of hallucinations (specify):

Intelligence Functioning:

☐ No Impairment	☐ Blackouts	☐ Seizures	☐ Abstract thinking
☐ Attention Span	☐ Concentration	☐ Conscious	☐ Intelligence

Thinking:

- ☐ No Impairment
- ☐ Associational disturbance
- ☐ Compulsions
- ☐ Confusion
- ☐ Delusions
- ☐ Depersonalization
- ☐ Homicidal Ideation
- ☐ Suicidal Ideation

Mental Health Symptoms:

- ☐ No Impairment
- ☐ ADHD
- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Suicidal Ideation
- ☐ Homicide Ideation
- ☐ Obsessive/ Compulsive Behavior
- ☐ PTSD
- ☐ Hallucinations/ Delusions
- ☐ Paranoia
- ☐ Anger
- ☐ Self-Mutilation
- ☐ Eating Disorder
- ☐ Sexual Complications
- ☐ Cognitive Impairment
- ☐ Other:

Are you currently taking any medication or have taken any medications in the past to help with your mental health?
If so list them and the dosage:

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Substance Use History:

- ☐ Alcohol How many drinks a week?
- ☐ THC
- ☐ Opiates
- ☐ Sedatives
- ☐ Cocaine
- ☐ Amphetamines:
- ☐ Inhalants
- ☐ Spice/Bath Salts
- ☐ Cigarettes

Any Substance Abuse Treatment? If so list the dates and outcome.

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Family of Origin History, Current Family Dynamics & Relationship History:

Educational/Work History/History of being bullied in school:

Legal History: Be sure to include a synopsis of all legal history on referral (such as 3 Dv's) and what they say including ask any juvenile history, # of years incarcerated, level of prison in.

Clinician's name and title Date