DOWNTOWN COUNSELING CENTER

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www.dcccarlisle.com

ADULT INTAKE INFORMATION FORM								
Part 1 – IDENTIFYING DATA								
Name (Last, First, MI)		Bir	th Date:		Today's Date			
A 11								
Address:								
II Ni		W	1. D1					
Home Phone:		Wo	Work Phone:					
Cell phone:		E-r	nail addro	ess:				
Gender: Male: Female:	Other:	[] (please specif	fy):					
	Pai	rt 2 – PRESENT	TING P	ROBLEM				
What is (are) your reason(s) for c	oming in today?							
How long have you been experien	ncing these probl	ems?						
	<i>8</i>							
Have you had difficulties like this	s before? Yes	☐ No (If yes, ple	ase expla	uin)				
Are you having any self-destruction	ve or suicidal tho	oughts? 🗌 Yes 🗀	No (If y	es, please explain)				
	Part 3	DAST DSVCI	плтрі	IC HISTORY				
Part 3 – PAST PSYCHIATRIC HISTORY List any previous psychiatric or substance abuse evaluations, counseling or hospitalizations:								
Reason		ation	Dates		Diagnosis (if known)			
List any previous psychiatric medication therapy: Medication Dates Effectiveness Side Effects Reason for Discontinuation								
MICGICACIOII	Dails	Effectivent	J	Side Effects	Reason for Discontinuation			

Have you ever attempted suicide	in the past? Yes [No (If yes, please	explain)		ı_			
•	-							
	Par	t 4 – MEDICAL 1	HISTORY					
Name and Location of Health Car			none of Health Ca	are Provider:				
List all allergies and reactions to 1	medications:							
List air aireigies aira reactione to	illedications.							
			10.10	. 1)				
List all medications that you are Name of Drug	e currently taking (p Amount taken		rt 18 if more space Name of Dru		mount taken (dose)			
Name of Drug	Amount taker	I (dose)	Name of Dru	g A	inount taken (dose)			
List all current and past medical or physical problems, including hospitalizations and traumatic injuries:								
List an current and past medical or physical problems, including hospitalizations and traumatic injuries:								
Are you currently experiencing severe pain, fever, dizziness, or lightheadedness? Yes No								
List any over the counter medications Herbal products				Supplements/Vitamins				
•	•							
Douglas A. DAINI A CCECCNIENIT								
Are you currently experiencing any physical pain? Yes No (If yes, please explain below)								
The you cantonary experiencing any physical paint. [] 105 [] 106 (1) yes, pieuse explain below)								
(If experiencing pain, please score your pain on a 10 point scale where $0 = no$ pain and $10 = worst$ pain imaginable)								
Please score your pain: 0 1 2 3 4 5 6 7 8 9 10								
Good pain day: /10 Average pain day: /10 Bad pain day: /10								
What do you do to help manage your pain on severe pain days?								

		UBSTANCE		_			
In the past year, have you e	ver drunk alcohol or used	drugs more than	you intend	ed?	Yes No		
In the past year, have you for	elt you wanted or needed t	o cut down on y	our alcohol	or drug use?	Yes No	_	
What, if any, recreational or illicit drugs or medications have you used recently or in the past?							
what, if any, recreational or finch drugs or medications have you used recently or in the past?							
Did you ever find that you needed to drink a lot more or use more drugs in order to get an effect, or that you							
could no longer get high on							
AUDIT Screening Tool			0	1	2	3	4
Instructions: Please che	ck the box that most app	lies to you.	Never	Monthly or less	2-4 times monthly	2-3 times weekly	4 + times weekly
1. How often do you hav	ve a drink containing alcol	hol?					
			1-2	3-4	5-6	7-9	10+
2. How many drinks contained day when you are drinking		e on a typical					
			Never	Monthly or less	Monthly	Weekly	Daily or almost daily
3. How often do you have	six or more drinks on one	occasion?					
4. How often during the la not able to stop drinking of		at you were					
5. How often during the la		do what was					
normally expected of you	normally expected of you because of drinking? 6. How often during the last year have you needed a first drink in						
the morning to get yourself going after a heavy drinking session?							
7. How often during the last year have you had a feeling of guilt or remorse after drinking?							
8. How often during the last year have you been unable to remember what happened the night before because of drinking?							
remember what happened the highe before because of drinking.			Never		Yes, but not in last year		Yes, during the last year
9. Have you or someone e drinking?	9. Have you or someone else been injured as a result of your						
10. Has anyone been conc	10. Has anyone been concerned about your drinking or suggested						
that you should cut down	Total AUDIT Score						
	Total AUDIT Score ←						
 	TOBACCO USE			CAFFEINE USE			
Do you smoke or use tobacco products? Yes No (If no please go to next section) What do you smoke or use? Cigarettes Snuff Cigars Pipe How many caffeinated beverages depends on average?					verages do yo	ou consume	
	Other:						
How much do you use in a day? How long have you been using tobacco products?				Do you ever feel irritable, jumpy or nervous because of your caffeine use? ☐ Yes ☐ No			
Do you wish to quit?				Does caffeine use impair your sleep? Yes No			
Do you wish to quit:			HIATRIC	· ·	use impan	your sicep.	
Part 6 – FAMILY PSYCHIATRIC HISTORY List any family members who have been diagnosed or treated for any mental health problems:							
Relationship Problem/Diagnosis				Hospitalized		Medications preso	
				☐ Yes ☐ No		•	
				Yes 🗌 No			
				☐ Yes ☐ No			
				☐ Yes ☐ No			

Have there been any death	Have there been any deaths or suicidal behavior in your family? Tes No (If yes, please explain)						
	PART 7 – 1	PSYCHOSOCIA	L / DEVELO	OPMENTA	L HISTO	ORY	
Where were you born?			Who raised	you? 🗌 Bot			☐ Father
				arent(s) \square A	doptive Pa	rent(s)	Other:
Were there any complication	ons at birth?	Yes \square No (If yes, p	lease explain	below)			
How many siblings do you	have and what i	number child were y	ou?				
What was it like in your ch	nildhood home?	Loving Com	fortable 🗌 Su	pportive	Chaotic _	Abusive	Other:
What type of discipline wa	s used in your cl	hildhood home?					
Did you have any develop	mental delays or	problems? Yes	No (If yes,)	please explai	in below)		
Have you ever been physic	cally, sexually or	emotionally abused	? :	No (If yes, p	lease expla	iin)	
	Part 8 - CU	RRENT FAMIL	Y RELATIO	ONSHIP AS	SSESSMI	ENT	
Marital Status?	Married Dive	orced Separated [Widowad	If married,	how long l	ave you b	een married?
If married, are you current				ge? 🗌 Yes [No1	N/A (If yes	, please explain)
		_		_			
Have you been married pro	eviously? Yes	s No No N/A (If	ves, please exp	olain)			
	•						
Do you have any concerns	about domestic	violence or abuse?	Yes No	(If yes, pleas	e explain)		
Have you or any of your sp		referred to any ager	ncy such as Ch	nild Protectiv	e Services	•	
Yes No (If yes, plea	se explain)						
Please list all your children: N/A (continue below, if needed) Child's name Child's age Child's Gender Biological or stepchild Does this child currently reside with you?							rently reside with you?
							,
						1	
Does anyone else reside in your household? Yes No (If yes, please explain below) Are you having any problems with your children? Yes No							
Are you having any problems with your emitten:							
Part 9 – RISK ASSESSMENT							
Are there any firearms in y Is there any history of dom		vour home?		<u> </u>		No No	
Do you have a history of suicidal or self-destructive thoughts or behaviors?							
Do you have a history of homicidal (harm to others) thoughts or behaviors?							

Do you have any other safety concerns at this time? (If ye	es, please explai	n)		Yes N	0			
Part 10 - SOC	CIAL SUPPO	RT ASS	SESSI	IENT				
Do you have someone to talk to when you have a probler	☐ Yes ☐ No							
Is there someone you would ask for help if you needed it?						☐ Yes ☐ No		
Are you geographically separated from family and friends?						☐ Yes ☐ No		
Are you having trouble with your relationships with family	Yes No							
Have you recently withdrawn from family or friends?						Yes No		
Do you belong to any groups or organizations that are su	pportive and hel	pful to y	/ou? 🗌	Yes 🗌 No (Į	f yes, ple	ease explain)		
Part 11 – SPIRIT	TUAL/ CULT	URAL	ASSES	SSMENT				
What is your religious or spiritual affiliation?								
How much is your religion or spirituality a source of stre								
		A great of	leal					
How much is your spiritual community a source of support								
Not at all Not very much Somewhat C		A great of		C 1				
Do you have any religious, spiritual or cultural practices treatment? Yes No (If yes, please explain)	tnat your provid	er needs	to be a	iware of during	5			
treatment: Tes No (1) yes, pieuse expluin)								
Part 12 - ED	UCATIONA	L ASSI	ESSMI	ENT				
	(year graduated			ome College				
4yr College (year graduated:) Masters (ye)		toral (year gra	duated:)		
Are you currently in school or training?				Yes [No			
Did you repeat or skip any grades?				Yes [□No	(If yes, please		
Did you attend any special education or gifted classes?				Yes	No			
Did you have any learning disabilities? Yes No						explain below)		
Did you have any disciplinary problems in school?								
If yes, were you ever suspended or expelled?								
PART 13 - LEGAL ASSESSMENT								
Have you ever been arrested?	- LEGAL A	Yes [No	·				
Are you currently on probation or parole?	_	Yes	No		(If ves	please explain below)		
Do you presently have any other legal problems?	<u> </u>	Yes	No		(I) yes,	, yes, picuse expiuiti veivw)		
bo you presently have any other regar problems.	ļ L	<u> </u>		J				
Part 14 – SEXUAL ASSESSMENT								
						, please explain below)		
Have you ever been sexually abused, assaulted or harasse	ed?		Yes	No	(-) 500	, r		
, according to the first of the	<u> </u>			-	i			

Part 15 -	LEISURE, RECREATIONA	AL AND VOCATIONAL ACTIVITI	ES			
What is your present job?						
Are there any problems with you	r present job?					
What do you like to do in your fr	ee time?					
What limits your ability or desire	to participate in leisure and recrea	ational activities?				
	Part 16 – NUTRITIO	ONAL ASSESSMENT				
Height:	Weight:	In the last month have you gained or lost Yes No (If yes, please explain bet				
How many meals do you eat per	day?					
	g underweight Binge eating tive Abuse Excessive die	Compulsive overeating Diuretic (Water pill) Abuse				
	Part 17 - FINANC	IAL ASSESSMENT				
Do you currently have any financial problems? Yes No (If yes, please explain below)						
		NT DISCLOSURE				
·	ou consent to have contacted regard	<u> </u>				
Spouse (Name):		☐ Gather further information ☐ Release information ☐ Make recommendations				
Supervisor (Name):		Gather further information Release information Make recommendations				
Doctor (Name):	_	Gather further information Release information Make recommendations				
Other Person/ Agency (Name): Gather furth	ner information Release information	Make recommendations			
Please use this space to tell us an	ything additional that you may fee	el is relevant or may be important for your p	provider to know.			
Patient Signature:		Date:				