DOWNTOWN COUNSELING CENTER
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ADULT INTAKE INFORMATION FORM

Part 1 – IDENTIFYING DATA

Name *(Last, First, MI)*	Birth Date:	Today's Date
Address:		
Home Phone:	Work Phone:	
Cell phone:	E-mail address:	

Gender: Male: ☐ Female: ☐ Other: ☐ (please specify):

Part 2 – PRESENTING PROBLEM

What is (are) your reason(s) for coming in today?

How long have you been experiencing these problems?

Have you had difficulties like this before? ☐ Yes ☐ No *(If yes, please explain)*

Are you having any self-destructive or suicidal thoughts? ☐ Yes ☐ No *(If yes, please explain)*

Part 3 – PAST PSYCHIATRIC HISTORY

List any previous psychiatric or substance abuse evaluations, counseling or hospitalizations:

Reason	Location	Dates	Diagnosis (if known)

List any previous psychiatric medication therapy:

Medication	Dates	Effectiveness	Side Effects	Reason for Discontinuation

Have you ever attempted suicide in the past? ☐ Yes ☐ No *(If yes, please explain)*

Part 4 – MEDICAL HISTORY

Name and Location of Health Care Provider:	Office Phone of Health Care Provider:

List all allergies and reactions to medications:

List **all medications that you are currently** taking (please continue in Part 18 if more space required):

Name of Drug	Amount taken (dose)	Name of Drug	Amount taken (dose)

List all 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

Part 4A - PAIN ASSESSMENT

Are you currently experiencing any physical pain? ☐ Yes ☐ No *(If yes, please 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?

Part 5 – SUBSTANCE USE ASSESSMENT

In the past year, have you ever drunk alcohol or used drugs more than you intended? ☐ Yes ☐ No

In the past year, have you felt you wanted or needed to cut down on your alcohol or drug use? ☐ Yes ☐ No

What, if any, recreational or illicit 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 the amount that you were using? ☐ N/A ☐ Yes ☐ No

AUDIT Screening Tool	0	1	2	3	4
Instructions: Please check the box that most applies to you.	**Never**	**Monthly or less**	**2-4 times monthly**	**2-3 times weekly**	**4 + times weekly**
1. How often do you have a drink containing alcohol?	☐	☐	☐	☐	☐
	1-2	**3-4**	**5-6**	**7-9**	**10+**
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐
	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 last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐
5. How often during the last year have you failed to do what was 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?	☐	☐	☐	☐	☐
	Never		**Yes, but not in last year**		**Yes, during the last year**
9. Have you or someone else been injured as a result of your drinking?	☐		☐		☐
10. Has anyone been concerned about your drinking or suggested that you should cut down	☐		☐		☐
Total AUDIT Score ←					

TOBACCO USE	**CAFFEINE USE**
Do you smoke or use tobacco products? ☐ Yes ☐ No *(If no please go to next section)*	How many caffeinated beverages do you consume per day on average?
What do you smoke or use? ☐ Cigarettes ☐ Snuff ☐ Cigars ☐ Pipe Other:	
How much do you use in a day?	Do you ever feel irritable, jumpy or nervous because of your caffeine use? ☐ Yes ☐ No
How long have you been using tobacco products?	
Do you wish to quit? ☐ Yes ☐ No	Does caffeine use impair your sleep? ☐ Yes ☐ No

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 prescribed?
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Have there been any deaths or suicidal behavior in your family? ☐ Yes ☐ No *(If yes, please explain)*

PART 7 – PSYCHOSOCIAL / DEVELOPMENTAL HISTORY

Where were you born?	Who raised you? ☐ Both Parents ☐ Mother ☐ Father ☐ Other Family ☐ Foster Parent(s) ☐ Adoptive Parent(s) ☐ Other:

Were there any complications at birth? ☐ Yes ☐ No *(If yes, please explain below)*

How many siblings do you have and what number child were you?

What was it like in your childhood home? ☐ Loving ☐ Comfortable ☐ Supportive ☐ Chaotic ☐ Abusive ☐ Other:

What type of discipline was used in your childhood home?

Did you have any developmental delays or problems? ☐ Yes ☐ No *(If yes, please explain below)*

Have you ever been physically, sexually or emotionally abused? : ☐ Yes ☐ No *(If yes, please explain)*

Part 8 - CURRENT FAMILY RELATIONSHIP ASSESSMENT

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	If married, how long have you been married?

If married, are you currently having any stressors or problems in your marriage? ☐ Yes ☐ No ☐ N/A *(If yes, please explain)*

Have you been married previously? ☐ Yes ☐ No ☐ N/A *(If yes, please explain)*

Do you have any concerns about domestic violence or abuse? ☐ Yes ☐ No *(If yes, please explain)*

Have you or any of your spouses ever been referred to any agency such as Child Protective Services?
☐ Yes ☐ No *(If yes, please 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?
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

Does anyone else reside in your household?	☐ Yes ☐ No	*(If yes, please explain below)*
Are you having any problems with your children?	☐ Yes ☐ No	

Part 9 – RISK ASSESSMENT

Are there any firearms in your home?	☐ Yes ☐ No
Is there any history of domestic violence in your home?	☐ Yes ☐ No
Do you have a history of suicidal or self-destructive thoughts or behaviors?	☐ Yes ☐ No
Do you have a history of homicidal (harm to others) thoughts or behaviors?	☐ Yes ☐ No

Do you have any other safety concerns at this time? *(If yes, please explain)*	☐ Yes ☐ No	

Part 10 - SOCIAL SUPPORT ASSESSMENT	
Do you have someone to talk to when you have a problem?	☐ 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, friends or coworkers?	☐ Yes ☐ No
Have you recently withdrawn from family or friends?	☐ Yes ☐ No

Do you belong to any groups or organizations that are supportive and helpful to you? ☐ Yes ☐ No *(If yes, please explain)*

Part 11 – SPIRITUAL/ CULTURAL ASSESSMENT

What is your religious or spiritual affiliation?

How much is your religion or spirituality a source of strength or comfort to you?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

How much is your spiritual community a source of support to you?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

Do you have any religious, spiritual or cultural practices that your provider needs to be aware of during treatment? ☐ Yes ☐ No *(If yes, please explain)*

Part 12 - EDUCATIONAL ASSESSMENT

Highest level of education completed? ☐ GED ☐ HS (year graduated:_____) ☐ Some College
☐ 4yr College (year graduated:_____) ☐ Masters (year graduated:_____) ☐ Doctoral (year graduated:_____)

Are you currently in school or training?	☐ Yes ☐ No	*(If yes, please explain below)*
Did you repeat or skip any grades?	☐ Yes ☐ No	
Did you attend any special education or gifted classes?	☐ Yes ☐ No	
Did you have any learning disabilities?	☐ Yes ☐ No	
Did you have any disciplinary problems in school?	☐ Yes ☐ No	
If yes, were you ever suspended or expelled?	☐ Yes ☐ No	

PART 13 - LEGAL ASSESSMENT

Have you ever been arrested?	☐ Yes ☐ No	*(If yes, please explain below)*
Are you currently on probation or parole?	☐ Yes ☐ No	
Do you presently have any other legal problems ?	☐ Yes ☐ No	

Part 14 – SEXUAL ASSESSMENT

Are you experiencing any sexual concerns?	☐ Yes ☐ No	*(If yes, please explain below)*
Have you ever been sexually abused, assaulted or harassed?	☐ Yes ☐ No	

Part 15 – LEISURE, RECREATIONAL AND VOCATIONAL ACTIVITIES

What is your present job?

Are there any problems with your present job?

What do you like to do in your free time?

What limits your ability or desire to participate in leisure and recreational activities?

Part 16 – NUTRITIONAL ASSESSMENT

Height:	Weight:	In the last month have you gained or lost weight without trying? ☐ Yes ☐ No *(If yes, please explain below)*

How many meals do you eat per day?

Have you ever had problems with: *(If checked, please explain)*

☐ Being overweight ☐ Being underweight ☐ Binge eating ☐ Compulsive overeating
☐ Vomiting ☐ Laxative Abuse ☐ Excessive dieting ☐ Diuretic (Water pill) Abuse
☐ Other eating disorders/problems:

Part 17 - FINANCIAL ASSESSMENT

Do you currently have any financial problems?	☐ Yes ☐ No	*(If yes, please explain below)*

Part 18 – PATIENT DISCLOSURE

Please list any individuals that you consent to have contacted regarding your care:

☐ 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 further information ☐ Release information ☐ Make recommendations

Please use this space to tell us anything additional that you may feel is relevant or may be important for your provider to know.

Patient Signature: _____ **Date**: _____