

DOWNTOWN COUNSELING CENTER
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ADULT INTAKE INFORMATION FORM

Part 1 – IDENTIFYING DATA

Name (<i>Last, First, MI</i>)		Birth Date:	Today's Date
Address:			
Home Phone:		Work Phone:	
Cell phone:		E-mail address:	
Gender: Male: <input type="checkbox"/> Female: <input type="checkbox"/> Other: <input type="checkbox"/> (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:
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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
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past year, have you felt you wanted or needed to cut down on your alcohol or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Monthly or less	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often during the last year have you been unable to remember what happened the night before because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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?	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
10. Has anyone been concerned about your drinking or suggested that you should cut down	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Total AUDIT Score	←				

TOBACCO USE

CAFFEINE USE

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

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? <i>(If yes, please explain)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Part 10 - SOCIAL SUPPORT ASSESSMENT		
Do you have someone to talk to when you have a problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there someone you would ask for help if you needed it?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you geographically separated from family and friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you having trouble with your relationships with family, friends or coworkers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you recently withdrawn from family or friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you belong to any groups or organizations that are supportive and helpful to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please explain)</i>		

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? <input type="checkbox"/> Not at all <input type="checkbox"/> Not very much <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> A great deal	
How much is your spiritual community a source of support to you? <input type="checkbox"/> Not at all <input type="checkbox"/> Not very much <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> A great deal	
Do you have any religious, spiritual or cultural practices that your provider needs to be aware of during treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please explain)</i>	

Part 12 - EDUCATIONAL ASSESSMENT		
Highest level of education completed? <input type="checkbox"/> GED <input type="checkbox"/> HS (year graduated: _____) <input type="checkbox"/> Some College <input type="checkbox"/> 4yr College (year graduated: _____) <input type="checkbox"/> Masters (year graduated: _____) <input type="checkbox"/> Doctoral (year graduated: _____)		
Are you currently in school or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Did you repeat or skip any grades?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you attend any special education or gifted classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you have any learning disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you have any disciplinary problems in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, were you ever suspended or expelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PART 13 - LEGAL ASSESSMENT		
Have you ever been arrested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Are you currently on probation or parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you presently have any other legal problems ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Part 14 – SEXUAL ASSESSMENT		
Are you experiencing any sexual concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, please explain below)</i>
Have you ever been sexually abused, assaulted or harassed?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> Spouse (Name) : | <input type="checkbox"/> Gather further information <input type="checkbox"/> Release information <input type="checkbox"/> Make recommendations |
| <input type="checkbox"/> Supervisor (Name): | <input type="checkbox"/> Gather further information <input type="checkbox"/> Release information <input type="checkbox"/> Make recommendations |
| <input type="checkbox"/> Doctor (Name): | <input type="checkbox"/> Gather further information <input type="checkbox"/> Release information <input type="checkbox"/> Make recommendations |
| <input type="checkbox"/> Other Person/ Agency (Name): | <input type="checkbox"/> Gather further information <input type="checkbox"/> Release information <input type="checkbox"/> 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:** _____