DOWNTOWN COUNSELING CENTER 155 S. Hanover St., Carlisle, PA 17013 PH: (717) 386-5971 F: (717) 386-5635 www.dcccarlisle.com

ADULT INTAKE INFORMATION FORM						
]	Part 1 – IDENT	TIFYING	G DATA		
Name (Last, First, MI)		Bi	rth Date:		Today's Date	
Address:						
Home Phone:		W	ork Phone	2:		
Cell phone:		E-	mail addr	ess.		
_						
Gender: Male: Fem	ale: Other	(please speci	ify):			
	Pa	rt 2 – PRESEN	TING P	ROBLEM		
What is (are) your reason(s) for						
How long have you been expe	eriencing these probl	ems?				
		_				
Have you had difficulties like	this before? [] Yes	No (If yes, pl	ease explo	un)		
				1 1		
Are you having any self-destru	uctive or suicidal the	bughts? \Box Yes \Box	\square No (If y	es, please explain)		
	Part 3	– PAST PSVC	HIATR	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	Effectiven	ess	Side Effects	Reason for Discontinuation	

Have you ever attempted suicide i	in the past?	$P \bigsqcup Yes \bigsqcup No (If)$	yes, please ex	plain)		
		Part 4 – ME				
Name and Location of Health Care Provider:Office Phone of Health Care Provider:						
List all allergies and reactions to r	nedication	s:				
List all medications that you are	currently	taking (please con	tinue in Part 1	8 if more spa	ce required):	
Name of Drug	Am	ount taken (dose)		Name of Dru	g	Amount taken (dose)
List all current and past medical o	r physical	problems, including	g hospitalizati	ons and traum	natic injuries:	
Are you currently experiencing se	vere pain,	fever, dizziness, or	lightheadedno	ess? 🗌 Yes	🗌 No	
List any over the counter medicat		Supplements/Vitamins				
5		Herbal products			11	
Part 4A - PAIN ASSESSMENT Are you currently experiencing any physical pain? Yes No (If yes, please explain below)						
The you currently experienceing any physical paint. 105 105 105 (1) yes, pieuse explain below)						
(If experiencing pain, please score yo	ur pain on c	10 point scale where	e 0 = no pain and a barrier of the pain and the pain an	$nd \ 10 = worst \ \mu$	pain imaginable))
Please score your pain: 0		3 4 5	6 7		0	
Good pain day: /10 Average pain day: /10 Bad pain day: /10						
What do you do to help manage y	our pain oi	n severe pain days?				

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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 y							
What, if any, recreational or illicit drugs or medications have you use							
Did you ever find that you needed to drink a lot more or use more dru							
could no longer get high on the amount that you were using?							
	2	4					
AUDIT Screening Tool	0 Never	Monthly	2 2-4 times	3 2-3 times	4 4 + times		
Instructions: Please check the box that most applies to you.	INCVCI	or less	monthly	weekly	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?			Yes. but		Yes, during		
	Never		not in last year		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		CAFFEI					
Do you smoke or use tobacco products? Yes No (If no please go to What do you smoke or use? Cigarettes Snuff Cigars F		How many caffeinated beverages do you consume per day on average?					
Other:							
How much do you use in a day?	Do you ever feel irritable, jumpy or nervous						
How long have you been using tobacco products?	because of your caffeine use?						
Do you wish to quit?	our sleep?	🗌 Yes 🗌 No					
Part 6 – FAMILY PSYCHIATRIC HISTORY							
List any family members who have been diagnosed or treated for any							
Relationship Problem/Diagnosis	Ho	Hospitalized N		Iedications prescribed?			
		🗌 Yes 🗌 No					
		Yes 🗌 No					
		Yes 🗌 No					
		Yes 🗌 No					

Have there been any deaths or suicidal behavior in your family?							
	PART 7 – I	PSYCHOSOCIA	L / DEVELO	PMENTA	L HIST	FORY	
Where were you born?			Who raised y			s \square Mother Parent(s) \square	Father Other:
Were there any complication	ons at birth?	Yes 🗌 No <i>(If yes, p</i>					
How many siblings do you	have and what n	umber child were y	ou?				
What was it like in your ch	ildhood home?	Loving Com	fortable 🗌 Sur	portive 🗌	Chaotic	Abusive	Other:
What type of discipline was	s used in your ch	ildhood home?					
Did you have any developm	nental delays or	problems? 🗌 Yes [No (If yes, p	lease expla	in below))	
Have you ever been physic	ally, sexually or	emotionally abused	? : 🗌 Yes 🗌 1	No <i>(If yes, p</i>	olease exp	plain)	
	Part 8 - CU	RRENT FAMIL	Y RELATIO	NSHIP A	SSESSI	MENT	
	Married 🗌 Divo	rced 🗌 Separated [Widowed	If married,	how long	g have you b	een married?
If married, are you currentl	y having any stro	essors or problems i	n your marriag	e? 🗌 Yes [No [] N/A (If yes	r, please explain)
Have you been married pre	viously? 🗌 Yes	□ No □ N/A (<i>lf</i>)	ves, please expl	lain)			
Do you have any concerns	about domestic v	violence or abuse?	Yes 🗌 No (If yes, pleas	e explair	n)	
Have you or any of your sp		referred to any ager	ncy such as Chi	ld Protectiv	e Service	es?	
Please list all your children	: N/A (contin	ue below, if needed	(-		
Child's name	Child's age	Child's Gender	Biological or	stepchild	Does t	this child cur	rently reside with you?
Does anyone else reside in Are you having any problem				Yes Yes	No No	(If yes,	please explain below)
	nis with your on					L	
		Part 9 – RI	SK ASSESSI	MENT			
Are there any firearms in y				[Yes	No	
Is there any history of dom				[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?							

Do you have any other safety concerns at this time? (If yes, pla	ease explain)	Yes 🗌	No	
Part 10 - SOCIAL	SUPPORT ASS	ESSMENT		
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?				
Are you geographically separated from family and friends?				
Are you having trouble with your relationships with family, fr	iends or coworkers	?		
Have you recently withdrawn from family or friends?		·		Yes No
Do you belong to any groups or organizations that are support	ive and helpful to v	ou? 🗌 Yes 🗌 No	(If ves_nleas	
be you belong to any groups of organizations that are support	ive and neipital to y		(1 <i>j</i> yes, preus	e explain)
Part 11 – SPIRITUAI	L/ CULTURAL A	ASSESSMENT		
What is your religious or spiritual affiliation?				
How much is your religion or spirituality a source of strength Not at all Not very much Somewhat Quite		eal		
How much is your spiritual community a source of support to Not at all Not very much Somewhat Quite	you?			
Do you have any religious, spiritual or cultural practices that y treatment? Yes No (If yes, please explain)			ing	
Part 12 - EDUCA	ATIONAL ASSE	SSMENT		
Highest level of education completed? GED HS (year 4yr College (year graduated:) Masters (year graduated:)	r graduated:)
Are you currently in school or training?				
Did you repeat or skip any grades?	s 🗌 No	(16		
Did you attend any special education or gifted classes?	s 🗌 No	(If yes, please explain below)		
Did you have any learning disabilities?	s 🗌 No	explain below)		
Did you have any disciplinary problems in school?	s No			
If yes, were you ever suspended or expelled?	s 🗌 No			
DADT 12 I	ECAL ASSESSM			
	EGAL ASSESS			
Have you ever been arrested?	Yes Ves] No	(If was -	aga amlair balaw
Are you currently on probation or parole? Do you presently have any other legal problems ?	Yes Yes] No] No	(1) yes, pl	ease explain below)
bo you presently have any other regar problems :		1110		

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?					
Por	t 16 – NUTRITIONAL ASSESSMENT					
Height: Weight:	In the last month have you gained or lost	weight without trying?				
	Yes No (If yes, please explain bel					
How many meals do you eat per day?						
Have you ever had problems with: (If checked,	please explain)					
Being overweight Being underweight						
Vomiting Laxative Abuse Other eating disorders/problems:	Excessive dieting Diuretic (Water pill) Abuse					
De	art 17 - FINANCIAL ASSESSMENT					
Do you currently have any financial problems?	Yes No	(If yes, please explain				
		below)				
Please list any individuals that you consent to h	Part 18 – PATIENT DISCLOSURE					
	Gather further information Release information	Maka racommondations				
Spouse (Name) :	Gather further information Release information					
Doctor (Name):		Make recommendations				
Other Person/ Agency (Name):	Gather further information Release information					
		Wake 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:					