ADULT INTAKE FORM

Today's Date:

Name: (First) (M.I.) (Last)

Age:

Relationship Status:

Gender Identification
Male ○ **Female** ○ **Other** ⊙

In Case of Emergency, please contact:

Phone:

Relationship:

Birth date:

Please give a brief description of why you are seeking treatment:_____

_____

Who referred you to our clinic?_____

FAMILY HISTORY

Your Parent's Name: _____ Age: Occupation: _____ Education level: ____

Your Parent's Name: _____ Age: ____ Occupation: _____ Education level: ____

Do you have a guardian? Contact info for guardian or parent: _____

Your Sibling(s): Age:

_____ _____ _____ _____ _____

Sex: _____ _____ _____ _____ _____

Were you adopted? Yes ○ No ○

Has there been any abuse in your history? None ☐ Physical ☐ Verbal/Emotional ☐ Sexual ☐

Describe any *family history* of mental health or chemical dependency problems or treatment:_____

_____

List any involvement with social services, court system or legal services: _____

_____

If applicable, your spouse/partner's name:_____ Age:_____ Occupation:_____

If applicable, list name, ages, and sex of each of your children:_____

_____

If applicable give date(s) of your marriage, separation(s) and/or divorce: _____

List current members of your household:_____

EDUCATION AND WORK HISTORY

Education (highest level obtained): _____ Current Employer:_____

How long employed there? _____ Occupation:_____

If you have been in the military, please list dates, rank and type of discharge:_____

_____

CHEMICAL USE HISTORY

Do you use tobacco products? Yes ○ No ○ If yes, type_____ quantity per day _____

Do you drink caffeine? Yes ○ No ○ If yes, type _____ quantity per day _____

Do you drink alcohol? Yes ○ No ○ If yes, usual number of drinks per day_____

Usual number of drinks per week_____

Please check any that are true for you	In the past month	Within last 12 months	Have used in past	Never
Cannabis- Marijuana, Hash	☐	☐	☐	☐
Amphetamines- Speed, Cocaine, Crack, Crank, Meth, Dexedrine, White Crosses, Ritalin, Cylert, etc.	☐	☐	☐	☐
Tranquilizers- Valium, Xanax, Ativan Librium, Sleeping Pills, Seconal, Quaaludes, etc.	☐	☐	☐	☐
Narcotics- Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.	☐	☐	☐	☐
Other- Inhalants, PCP, LSD Mushrooms, Paint Thinner, Glue Nitrite "Poppers", etc.	☐	☐	☐	☐

Have you ever felt you ought to cut down on your drinking or drug use? Yes ○ No ○

Have you ever had people annoy you by criticizing your drinking or drug use? Yes ○ No ○

Have you ever felt bad or guilty about your drinking or drug use? Yes ○ No ○

Have you ever had to drink or use drugs as an "eye opener" first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? Yes ○ No ○

PREVIOUS TREATMENT

List any psychological/psychiatric treatment you have had:

_____

_____

List dates of any psychiatric hospitalizations you have had:

_____

_____

List dates of any treatment for chemical dependency you have had:

_____

_____

Have you or any other member of your family ever been seen for services through BHSI? Yes ○ No ○

If so, who and when? _____

MEDICAL HISTORY

Primary Care Clinic: _____ Physician: _____

Date of last physical? _____Drug Allergies? _____

Describe any current medical conditions: _____

Describe any past medical conditions including surgeries: _____

List any history of head injury, including concussion or loss of consciousness:
_____
_____

For this next segment, please note that we are asking for current and past medications:

Please list any current medications you are prescribed, as well as supplements or consistent use of over the counter medications:

Are there any medications you are prescribed, but that you are not taking? If so, please list the reason you are not taking the medication (e.g. side effects, cost)

Please list any previous medications you have taken to help in managing your moods or behaviors:

Please check the boxes of all other problems that you've had during this *last month.*
Then, in the space that follows each problem tell us when you first noticed these problems.

- ☐ Fears of crowds or having to talk to people
- ☐ Feeling panic, heart pounding, feel like I'm losing it, I can't stand it
- ☐ Can't get to sleep, or stay asleep
- ☐ Sudden horrible memories or bad nightmares
- ☐ Feeling that I have to do or think something over and over
- ☐ Worrying a lot about germs, diseases, my health
- ☐ Wanting to get revenge or hurt other people
- ☐ Thoughts racing faster than I can follow them
- ☐ Very extreme happiness or ambition
- ☐ Hearing voices in my head or other strange experiences
- ☐ Feeling like people are following me, monitoring me, or plotting to hurt me somehow
- ☐ Out of control spending or gambling
- ☐ Using drugs or drinking too much
- ☐ Out of control eating
- ☐ Dieting too much, or using laxatives or vomiting to lose weight
- ☐ Concerns about sex
- ☐ Frequent headaches
- ☐ Loss of balance
- ☐ Numbness
- ☐ Sudden vomiting
- ☐ Frequent, constant, and/or extreme pain
- ☐ Other problems:_____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	◉	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being fidgety or restless—moving around a lot	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

For items 1-9, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ○ **Somewhat difficult** ○ **Very difficult** ○ **Extremely difficult** ○

For items 1-9, when did you first notice these problems? _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than Half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	○	○	○	○
2. Not being able to stop or control worrying	○	○	○	○
3. Worry too much about different things	○	○	○	○
4. Trouble relaxing	○	○	○	○
5. Being so restless that it is hard to sit still	○	○	○	○
6. Becoming easily annoyed or irritable	○	○	○	○
7. Feeling afraid, as if something awful might happen	○	○	○	○

For items 1-7, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ○ **Somewhat difficult** ○ **Very difficult** ○ **Extremely difficult** ○

Other information you would like to provide: