CLINICAL INTAKE

ADULT INFORMATION & HISTORY

1. Family Relationships

FAMILY MEMBER NAME	AGE	DECEASED	QUALITY OF RELATIONSHIP		
			GOOD	FAIR	POOR
Mother:					
Father:					
Brothers and / or Sisters: (Please List)					
NAME	**AGE**				
Spouse / Partner:					
Children:					

2. Briefly describe the family in which you were raised and any concerns you may have about your family:

_____

_____

_____

_____

3. Who are the supportive/helpful people in your life?

NAMES	HOW DO THEY HELP YOU?

4. Did you experience any problems as a child learning how to walk, talk, or learn other skills?
___ YES ___ NO Please explain:

_____

_____

5. Please note the highest-grade level you completed in school: _____
What where your average grades? _____

6. Briefly describe your relationship with:
Friends:_____
_____
_____

Teachers: _____
_____
_____

7. Employment History (Past 3 Years)

EMPLOYER	POSITION HELD	HOW LONG EMPLOYED

8. Have you served in the Military? ____YES ____NO

Length of Service:	
Date of Discharge:	
Type of Discharge:	
Service-related Disability:	
Military Branch:	

9. Please describe your personal interests and hobbies:
_____
_____
_____

What activities do you do to reduce stress/relax?
_____

10. What have you tried that worked on your presenting problem?
_____

What have you tried that did not work on your presenting problem?
_____
_____

11. Medical / Medication History: **Doctor's Name(s): _______**

Prescribed / Over-the-Counter				Currently Taking		Taken as Prescribed	
Name of Prescribed Medication:	**Reason:**	**Dosage:**	**How Often:**	**Yes**	**No**	**Yes**	**No**

Adverse Drug Reactions:

_____

_____

12. Allergies to Medication:

_____

_____

13. Current Health: **____ Excellent** **____ Good** **____ Fair** **____ Poor**

	Yes	No	Dates and/or Age		Comments
Past Surgery					
Head Injury					
Loss of Consciousness					
Seizures					

14. Do you have or have you had any of the following illnesses?

	Present	Past	Family History Of
Diabetes			
Thyroid Disorder			
Heart Trouble			
Heart Attack			
Angina			
High Blood Pressure			
Stroke			
Asthma			
Hepatitis / Jaundice			
Liver Disease			
Emphysema			
Bronchitis			

	Present	Past	Family History Of
Arthritis			
Ulcers			
Low Blood Pressure			
Cancer			
Abnormal Bleeding			
Anemia			
Depression			
Bi-Polar Disorder			
Schizophrenia			
Anxiety			
Vision Problems			
Hearing Problems			
Dental Problems			

If other illnesses, please list for self:

_____

_____

15. HAVE YOU RECEIVED ANY KIND OF MENTAL HEALTH TREATMENT SUCH AS COUNSELING, HOSPITALIZATON, TESTING? _____YES _____NO

REASON FOR TREATMENT: _____

DESCRIBE TREATMENT: _____

_____

TREATMENT DATES: _____ THERAPIST NAME:_____

HAS THERE BEEN ANY LEGAL ACTION AS A RESULT OF THE TREATMENT? _____YES _____NO

IF YES, PLEASE EXPLAIN:

_____

_____

_____

THANK YOU FOR YOUR PATIENCE IN COMPLETING THIS FORM

Form Completed By: _____ Date: _____

PSYCHOLOGIST'S SIGNATURE:		**DATE:**	