



ADULT INTAKE-ASSESSMENT

Today's Date: _____

Full Name:		Date of Birth: mm / dd / yyyy		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced (No. of times _____) <input type="checkbox"/> Widow/er <input type="checkbox"/> Cohabiting <input type="checkbox"/> Never Married					
Total number of people living in your household:			Ages of children:		
Highest Education Completed: <input type="checkbox"/> Primary <input type="checkbox"/> High School/GED <input type="checkbox"/> Some college <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> MA/MS <input type="checkbox"/> PhD <input type="checkbox"/> Other					
Employment: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student Type of work/position:					
Ethnic Origin:		Religion:		Practicing/Active? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you need any cultural or language assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify:					
What is the reason for your visit today?					
What symptoms do you notice?					
When did the problem first start?					
List the clinicians (and their phone numbers) you have seen for this condition. No one will be contacted without your permission.					
List any medications you have taken for this current problem					
Current Medications		Dose	Frequency	For how long?	Prescribing MD
List any/all allergies: <input type="checkbox"/> None					
Please indicate if you have a family history of any of the following conditions. (Check all that apply)					
	<u>Mother's Side</u>	<u>Father's Side</u>		<u>Mother's Side</u>	<u>Father's Side</u>
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Motor or vocal tics	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Attention or concentration problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Restlessness or fidgeting	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Motor incoordination	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Drug or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Serious medical illness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Depression or mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anxieties, fears, or phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychosis or schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Relationship problems/issues	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychiatric hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Divorce	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Suicide/suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Homicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>

Check any of the terms that describe you when you were growing up:					<input type="checkbox"/> None
<input type="checkbox"/> Selfish	<input type="checkbox"/> Stealing	<input type="checkbox"/> Inattentive	<input type="checkbox"/> Argumentative	<input type="checkbox"/> Distractible	<input type="checkbox"/> Sad
<input type="checkbox"/> Defiant	<input type="checkbox"/> Hurt Animals	<input type="checkbox"/> Fidgety	<input type="checkbox"/> Willful	<input type="checkbox"/> Restless	<input type="checkbox"/> Sickly
<input type="checkbox"/> Set Fires	<input type="checkbox"/> Destructive	<input type="checkbox"/> Anti-authority	<input type="checkbox"/> Call out in class	<input type="checkbox"/> Abusive	<input type="checkbox"/> Anxious
<input type="checkbox"/> Lack Conscience	<input type="checkbox"/> Liar	<input type="checkbox"/> Combative	<input type="checkbox"/> Bully	<input type="checkbox"/> Cheater	<input type="checkbox"/> Loser
<input type="checkbox"/> Short attention	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Risky Behaviors	<input type="checkbox"/> Can't wait for turn	<input type="checkbox"/> Hateful	<input type="checkbox"/> Bullied
<input type="checkbox"/> Whiny	<input type="checkbox"/> Demanding	<input type="checkbox"/> Irresponsible	<input type="checkbox"/> Disrespectful	<input type="checkbox"/> Uncaring	<input type="checkbox"/> Unattractive

MEDICAL PROBLEMS - List all past and present medical problems including surgeries or accidents. None

Medical condition	Age at onset

PSYCHIATRIC HOSPITALIZATION - List any hospitalizations you've had for psychiatric problems (whether it's for the current problem or other reasons). Use the other side of this page if more space is needed. None

When	Where	Why

OUTPATIENT TREATMENT - List any outpatient treatment you've had for the following: None

Problem	When	Where	Specific Reason
Mental Health			
Substance Abuse			
Gambling			

RECENT STRESSFUL LIFE EVENTS - Check all that apply among the following events that have occurred in the last 2 years. None

Engaged Married Separated Divorce Death of spouse or other relation
 Pregnancy Retirement Child left home Blended family Breakup of important relationship
 Moved/new home Foreclosure Major Illness Personal injury Bad health/behavior of a family member
 Unemployment Owe money Bankruptcy Legal problems Care for elderly/ill parent at home
 Other (please specify)

Many of the following questions may not apply to you. Some may seem strange or even difficult to answer. Just do your best to answer. Mark any/all statements below based on what you may have experienced. (Check all that apply)

While not on drugs, I remember experiencing the following. (Check all that apply) None

I've had severe mood swings I've had bizarre or very unusual thoughts
 I've heard voices or sometimes talked to myself I've experienced seeing things/having visual hallucinations

Suicide <input type="checkbox"/> Never	<input type="checkbox"/> I have thought about suicide. If so, when was the last time?
	<input type="checkbox"/> I have attempted suicide. If so, when and how?
Violence <input type="checkbox"/> Never	<input type="checkbox"/> I've thought about hurting someone. If so, when was the last time?
	<input type="checkbox"/> I've harmed/hurt someone else. If so, when and how?
	<input type="checkbox"/> I'm thinking of hurting someone now. If so, who?
Legal Matters <input type="checkbox"/> Never	<input type="checkbox"/> I've been arrested. If so, when/what reason?
	<input type="checkbox"/> I've been convicted of a felony. If so, when/what reason?
	<input type="checkbox"/> I have a pending law suit. Specify:
Smoking <input type="checkbox"/> Never	<input type="checkbox"/> I have smoked/chewed tobacco. If so, how many packs/day? For how long?

Caffeine Drinks <input type="checkbox"/> None	I drink this many cups of coffee per day <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More <input type="checkbox"/> Not daily I drink this many cups of tea per day <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More <input type="checkbox"/> Not daily I drink this many cans of soda per day <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More <input type="checkbox"/> Not daily	
Weight Change <input type="checkbox"/> None	<input type="checkbox"/> I lost/gained weight more than 10 lbs. in the last 6 months. Current weight: _____ lbs. Height: _____ ft. _____ in.	
Feminine Issues <input type="checkbox"/> None	<input type="checkbox"/> I have irregular periods. <input type="checkbox"/> I've been pregnant _____ times. <input type="checkbox"/> I take oral contraceptives. <input type="checkbox"/> I feel pain and discomfort when I'm on my period. <input type="checkbox"/> I've had _____ miscarriages. <input type="checkbox"/> My contraceptives affect my mood. <input type="checkbox"/> I get moody, irritable, depressed, or irrational during my period. <input type="checkbox"/> I've had _____ abortions. <input type="checkbox"/> I am currently menopausal <input type="checkbox"/> I have _____ living children. <input type="checkbox"/> I am past menopause	
Sexual Issues <input type="checkbox"/> None	Male Difficulties: <input type="checkbox"/> Partner <input type="checkbox"/> Lack of interest <input type="checkbox"/> Ejaculation <input type="checkbox"/> Masturbation <input type="checkbox"/> Erectile <input type="checkbox"/> Premature ejaculation Female Difficulties: <input type="checkbox"/> Partner <input type="checkbox"/> Lack of interest <input type="checkbox"/> Feeling used <input type="checkbox"/> Masturbation <input type="checkbox"/> No orgasm <input type="checkbox"/> Painful orgasm	
Sadness and Depression <input type="checkbox"/> None of the statements apply	<input type="checkbox"/> I go through periods of sadness or depression. <input type="checkbox"/> I have periods of low energy. <input type="checkbox"/> I lose interest in everything. <input type="checkbox"/> I have periods of slowed activities or restlessness. <input type="checkbox"/> I have changes in appetite or lose/gain weight <input type="checkbox"/> I have difficulty falling asleep or oversleeping. <input type="checkbox"/> I have recurrent thoughts of death or suicide. <input type="checkbox"/> These thoughts/moods come and go. <input type="checkbox"/> These feelings come out of the blue. <input type="checkbox"/> They happen in reaction to bad things that happen. <input type="checkbox"/> These thoughts/moods gotten worse over the last 2 weeks. <input type="checkbox"/> These thoughts/moods last and last. <input type="checkbox"/> I've had these moods constantly for at least one year.	
Sleep <input type="checkbox"/> None of the statements apply	<input type="checkbox"/> I tend to oversleep. <input type="checkbox"/> I have nightmares. <input type="checkbox"/> I need regular naps. <input type="checkbox"/> I wake up short of breath or in a panic. <input type="checkbox"/> I have a hard time falling asleep. <input type="checkbox"/> I wake up with headaches. <input type="checkbox"/> I wake up in the middle of the night or too early in the morning.	
Anxiety or Fear Answer these questions as they apply to your feelings or symptoms most days for the last 6 months. <input type="checkbox"/> None of the statements apply	<input type="checkbox"/> I feel on edge, fearful or anxious. <input type="checkbox"/> I've had sleeping problems (falling or staying asleep). <input type="checkbox"/> I get easily fatigued. <input type="checkbox"/> I worry excessively about things I find hard to control. <input type="checkbox"/> I have difficulties concentrating or my mind goes blank. <input type="checkbox"/> When I'm nervous, I feel my heart race or miss beats. <input type="checkbox"/> I feel irritable. <input type="checkbox"/> When I'm nervous, I feel shaky, sweaty or flushed. <input type="checkbox"/> I have muscle tension. <input type="checkbox"/> When I'm nervous, I have trouble breathing or swallowing. <input type="checkbox"/> I feel numb or like I'm outside my body. <input type="checkbox"/> When I'm nervous, I feel chest pain or discomfort. <input type="checkbox"/> I have chills or hot flashes. <input type="checkbox"/> When I'm nervous, I get nauseated or sick to my stomach. <input type="checkbox"/> I sometimes feel that things are not real? <input type="checkbox"/> When I'm nervous, I get dizzy or feel faint? <input type="checkbox"/> I sometimes feel like I'm going crazy or losing control. <input type="checkbox"/> My anxiety comes in attacks and goes away just as fast. <input type="checkbox"/> I have a fear of dying. <input type="checkbox"/> It always goes on all the time or <input type="checkbox"/> only for a few days. <input type="checkbox"/> My anxiety affects aspects of my life. <input type="checkbox"/> I have unrealistic fears of people, places, or things. <input type="checkbox"/> I have trouble leaving my house, being in crowds or speaking in public. <input type="checkbox"/> I frequently recall terrible events that have happened to me or that I have witnessed. <input type="checkbox"/> I have memories that are so real the event feels like it is really happening.	
Emotional Well-Being <input type="checkbox"/> None of the statements apply	<input type="checkbox"/> I've had weird body or facial movements. <input type="checkbox"/> I have been sexually abused. <input type="checkbox"/> I feel I have to clear throat or nose sniffing often. <input type="checkbox"/> When I was growing up, I have witnessed or experienced physical abuse from caretaker(s). <input type="checkbox"/> My hands shake much of the time. <input type="checkbox"/> I've had blackouts, fits or seizures. <input type="checkbox"/> Other parts of my body jerk or twitch uncontrollably. <input type="checkbox"/> I have fainted and then wet or soiled my clothes. <input type="checkbox"/> Other parts of my body jerk or twitch uncontrollably when I feel nervous. <input type="checkbox"/> I smell things that no one else smells, such as burnt rubber, urine, feces or old socks. <input type="checkbox"/> Other parts of my body jerk or twitch uncontrollably at night when I'm trying to sleep. <input type="checkbox"/> I hear or see things that other people do not see or hear. <input type="checkbox"/> I frequently eat more than normal amounts of food at one time. <input type="checkbox"/> I often have headaches. <input type="checkbox"/> I take laxatives, make myself throw-up or exercise excessively to keep me from gaining weight <input type="checkbox"/> I frequently get lost or have problems with my memory. <input type="checkbox"/> I'm concerned about my sexual drive or behavior in some way. <input type="checkbox"/> I have sensed that walls were breathing or objects were changing in size. <input type="checkbox"/> I'm concerned about some of my sexual habits that I think are unacceptable. <input type="checkbox"/> I've had thoughts that just won't go away.	

Patient Name: _____

<p>Emotional Well-Being</p> <p><input type="checkbox"/> None of the statements apply</p>	<p><input type="checkbox"/> I do things over and over again almost unable to stop.</p> <p><input type="checkbox"/> I feel the urge to check my body often, lock the door over and over again, wash my hand, count or have everything just right.</p> <p><input type="checkbox"/> If I try to control these behaviors, I get uncomfortable or anxious.</p> <p><input type="checkbox"/> Others might describe me as rigid.</p> <p><input type="checkbox"/> I take things very seriously to the point that I have rituals, routines, or habits that don't seem to make any sense.</p> <p><input type="checkbox"/> I tend to treat others very poorly.</p> <p><input type="checkbox"/> I tend to act unusually rude, hostile or argumentative.</p> <p><input type="checkbox"/> I feel shame or regret later.</p> <p><input type="checkbox"/> I've gone several nights without sleep</p> <p><input type="checkbox"/> I've spent a lot of money</p> <p><input type="checkbox"/> I've used excessive amounts of drugs or alcohol</p> <p><input type="checkbox"/> I've given away things that I treasure</p> <p><input type="checkbox"/> I've felt lots of energy or powerful, exceptional or superior.</p> <p><input type="checkbox"/> I act or feel incredibly strong or smart.</p> <p><input type="checkbox"/> I've felt extremely jealous or envious.</p> <p><input type="checkbox"/> I've had times when I stopped taking care myself, such as bathing, shaving or getting dressed.</p> <p><input type="checkbox"/> Bizarre things have happened to me, like hearing voices, swearing or talking.</p> <p><input type="checkbox"/> The Radio or TV talked to me like some programs were directed especially for me.</p> <p><input type="checkbox"/> I've had thoughts or beliefs that others might find irrational or hard to believe.</p> <p><input type="checkbox"/> I seem to have more than a normal number of medical illnesses or conditions.</p>									
<p>Gambling</p> <p><input type="checkbox"/> None of the statements apply</p>	<p>I gamble <input type="checkbox"/> Everyday <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> 4-5 times a week <input type="checkbox"/> Weekends <input type="checkbox"/> Occasionally</p> <p>When I gamble, I usually invest = \$_____ The largest amount of money I've won = \$_____</p> <p><input type="checkbox"/> The more money gamble the more exciting it feels!</p> <p><input type="checkbox"/> I don't tell my spouse/others how much I <i>really</i> gamble.</p> <p><input type="checkbox"/> I always think of ways increase my chances of winning.</p> <p><input type="checkbox"/> I always think of ways to get money so I can gamble.</p> <p><input type="checkbox"/> I think of when and where I'm going to gamble next.</p> <p><input type="checkbox"/> I tried but I can't control, cut back or stop gambling</p> <p><input type="checkbox"/> I'm restless/irritable when I try to cut down or stop gambling.</p> <p><input type="checkbox"/> I gamble to feel better or as a way to escape problems.</p> <p><input type="checkbox"/> When I lose money gambling, I go back another day to get even.</p> <p><input type="checkbox"/> I've committed illegal acts in order to pay for gambling (i.e., passing bad checks or taking money that didn't belong to me, etc.)</p> <p><input type="checkbox"/> I have jeopardized or lost a significant relationship, job or education opportunity because of gambling.</p> <p><input type="checkbox"/> I have relied on others to provide money to relieve a desperate financial situation caused by gambling.</p> <p>Last time I've gambled was:_____ How many years have I been gambling? _____</p>									
<p>Alcohol and Drug Use</p> <p><input type="checkbox"/> None of the statements apply</p>	<p>I drink alcohol <input type="checkbox"/> Everyday <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 3-5 times a week <input type="checkbox"/> Weekends <input type="checkbox"/> Occasionally</p> <p>On an average day, I usually drink <input type="checkbox"/> 1-2 shots/bottles of beer <input type="checkbox"/> 3-6 shots/bottles of beer</p> <p style="padding-left: 100px;"><input type="checkbox"/> more than 6 shots/bottles of beer</p> <p>The most I've drank in a 24-hour period was: <input type="checkbox"/> 1-2 shots/bottles of beer <input type="checkbox"/> 3-6 shots/bottles of beer</p> <p style="padding-left: 100px;"><input type="checkbox"/> more than 6 shots/bottles of beer</p> <p>Last time I've had a drink was:_____ How many years have I been drinking? _____</p> <p>I have taken or experimented with the following substances: (Check all that apply)</p> <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Marijuana</td> <td><input type="checkbox"/> Cocaine/crack</td> <td><input type="checkbox"/> Loritabs, Oxycontin, Vicodin, or other pain killers</td> </tr> <tr> <td><input type="checkbox"/> Heroin/Opiate</td> <td><input type="checkbox"/> LSD/Hallucinogens/PCP</td> <td><input type="checkbox"/> Inhalants, glue, paint, gasoline, aerosols</td> </tr> <tr> <td><input type="checkbox"/> Amphetamine/Speed</td> <td><input type="checkbox"/> Xanax, Valium, Ativan, etc.</td> <td><input type="checkbox"/> Other</td> </tr> </table> <p>How frequent do I use drugs? <input type="checkbox"/> Daily <input type="checkbox"/> 3-5 times a week <input type="checkbox"/> Occasionally</p> <p style="padding-left: 100px;"><input type="checkbox"/> 1-2 times a week <input type="checkbox"/> Weekends</p> <p>Last time I've used drugs was:_____ How many years have I been using? _____</p> <p><input type="checkbox"/> I've been told or felt that I should cut down on my drinking or drug use.</p> <p><input type="checkbox"/> I've felt annoyed by people criticizing me about my drinking or drug use.</p> <p><input type="checkbox"/> I've felt bad or guilty about my drinking/drug use.</p> <p><input type="checkbox"/> I have drank or used drugs first thing in the morning as an eye-opener to steady my nerves or get rid of my hangover.</p>	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Cocaine/crack	<input type="checkbox"/> Loritabs, Oxycontin, Vicodin, or other pain killers	<input type="checkbox"/> Heroin/Opiate	<input type="checkbox"/> LSD/Hallucinogens/PCP	<input type="checkbox"/> Inhalants, glue, paint, gasoline, aerosols	<input type="checkbox"/> Amphetamine/Speed	<input type="checkbox"/> Xanax, Valium, Ativan, etc.	<input type="checkbox"/> Other
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Cocaine/crack	<input type="checkbox"/> Loritabs, Oxycontin, Vicodin, or other pain killers								
<input type="checkbox"/> Heroin/Opiate	<input type="checkbox"/> LSD/Hallucinogens/PCP	<input type="checkbox"/> Inhalants, glue, paint, gasoline, aerosols								
<input type="checkbox"/> Amphetamine/Speed	<input type="checkbox"/> Xanax, Valium, Ativan, etc.	<input type="checkbox"/> Other								
<p>Give more details, if you can.</p> <p>_____</p> <p>_____</p> <p>_____</p>										

Patient Signature: _____
If this form is being submitted electronically, enter the full name of the signer.

Reviewed by
Clinician: _____

Date: _____

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Patient Name: _____