

ADULT INTAKE FORM

Today's Date: _____

Name: (First) (M.I.) (Last)	Age:	
Relationship Status:	Pronouns:	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: