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ADULT INTAKE FORM

The following information is requested so that I may provide you with the best service possible. This information is confidential and shall be protected as such. For a summary of how I provide psychological/counseling services, please read the **Office Policies and Procedures** included with your intake packet.

Client's Name_____Birth Date ____/____/____ Age _____ Sex ____Today's Date ____/____/____
Last First Middle

If not client, name of person completing this form _____Relationship to client_____

_____ _____
Home Address City State Zip

Home phone _____Business phone _____Cell phone _____
E-mail address_____ Person to call in an emergency_____
Primary Language _____Secondary Language _____ If not English age learned_____

Purpose of consultation (brief summary of the main problems):_____
_____
_____
_____
_____
_____

Date of onset of problems: ____/____/____ Date of accident: ____/____/____ Date of injury: ____/____/____

What specific questions or goals do you have for the evaluation or for counseling:
1._____ _____

2._____ _____

3._____ _____

4._____ _____

I would like or have been referred for: ☐ Counseling ☐ Evaluation ☐ Psychological Testing ☐ Neuropsychological Testing ☐ Unsure

Person/s who referred you:_____ Physician:_____
Name Tel # Name Tel#

Medical Specialists: _____ May I contact physician to coordinate care: ☐ Yes ☐ No
_____

FAMILY INFORMATION

Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____
Years Married _____ Year of Marriage_____ Spouse's Health ☐ Excellent ☐ Good ☐ Poor

If separated or divorced: When was separation? ____ divorce? ____ Who has legal custody of your children ☐ Mother ☐ Father ☐ Joint

Please list all additional members of your immediate family including yourself:

Name	Relationship	Age	Birth Date	Highest Grade Comp.	Occupation

DEVELOPMENTAL HISTORY

(Please check all items that apply.)

Mother's Pregnancy

☐ Accident_____ ☐ Hospitalization required_____
☐ Poor Nutrition_____ ☐ Threatened miscarriage_____
☐ Infection(s) (specify)_____ ☐ Toxemia/Preeclampsia_____
☐ Operation(s) (specify)_____ ☐ Other illnesses) (specify)_____
☐ Medications taken _____ ☐ X-ray studies_____
☐ Smoking :Ave cigarettes per day_____ ☐ Alcoholic consumption beyond an occasional drink_____
☐ Drug Use:_____ Activity level of fetus while in utero: ☐ High ☐ Medium ☐ Low

Delivery

Type of labor: ☐ Spontaneous ☐ Induced ☐ Emergency Length of Pregnancy_____ Birth Weight_____
Type of delivery: ☐Headfirst ☐ Breech ☐ Extremities ☐ Cesarean_____
Forceps: ☐high_____ ☐ mid _____ ☐ low_____ Suction ☐ Yes ☐ No Duration of labor hours_____
☐ Cord around neck_____ ☐ Cord presented first_____
☐ Hemorrhage_____ ☐ Fetal distress _____
☐ Placenta Previa_____ ☐ Other_____
Respiration: ☐ Immediate_____ ☐ Delayed (if so, how long)_____
☐ Cyanosis (turned blue)_____ ☐ Mucus accumulation_____
☐ Ingested Meconium_____ APGAR scores at delivery (if known): 1 minute_____ 5 minutes_____
☐ Jaundice ☐ Bilirubin Treatment (blue lights)–specify treatment length _____
☐ Rh factor ☐ Transfusion ☐ Injection _____
☐ Incubator–specify _____ # Days _____
☐ Intensive care–specify _____ # Days _____
☐ Birth defects–specify _____

Infancy/Toddler/Childhood Period–Were any of the following present to a significant degree during your first few years of life? If so describe.

☐ Excessive restlessness _____
☐ Diminished sleep because of restlessness and easy arousal _____
☐ Constantly into everything _____
☐ Excessive number of accidents compared to other children _____
☐ Attentional Problems_____
☐ Clumsiness_____
☐ Muscle Weakness_____
☐ Speech Problems_____
☐ Hearing Problems_____
☐ Vision Problems_____
☐ Learning Disabilities_____

DEVELOPMENTAL MILESTONES

If you can recall, check the age at which your child demonstrated the following behaviors.

	Early	**Average**	**Late**	**Never**
Walking	☐	☐	☐	☐
Receptive Speech	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Expressive Speech	☐	☐	☐	☐
Walked without assistance	☐	☐	☐	☐
Gross Motor Development	☐	☐	☐	☐
Fine Motor Development	☐	☐	☐	☐

COORDINATION

Rate your child on the following skills:

	Good	***Average***	***Poor***
Walking	☐	☐	☐ _____
Running	☐	☐	☐ _____
Throwing	☐	☐	☐ _____
Catching	☐	☐	☐ _____
Bike Riding	☐	☐	☐ _____
Athletic ability	☐	☐	☐ _____
Shoelace tying	☐	☐	☐ _____
Buttoning	☐	☐	☐ _____
Writing	☐	☐	☐ _____

MEDICAL HISTORY

If your medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information. This section should include medical problems **PRIOR** to the onset of your current conditions.

☐ Childhood diseases (describe any complications) _____

_____ ☐

Hospitalizations for illness (exclude operations) _____

_____

☐ Hearing problems _____

☐ EU tubes _____

☐ Poisoning _____

☐ Surgery _____

_____

☐ Head Injuries ☐ with unconsciousness ☐ without unconsciousness _____

_____

☐ Sports Concussions/Injuries _____

☐ Convulsions ☐ with fever _____ ☐ without fever _____

☐ Coma _____

☐ Meningitis/encephalitis _____

☐ Involved in automobile accident _____

_____

☐ Involved in work accident _____

_____

☐ Surgeries _____

_____

☐ Seizures _____

☐ Stroke _____

☐ Vision problems _____ ☐ Wears glasses/contacts _____

☐ Dementia _____

☐ Arteriosclerosis _____

☐ Heart Disease _____

☐ Cancer _____

☐ Allergies _____

☐ Other _____

PRESENT MEDICAL STATUS

☐ Present illness(es) for which you are being treated _____

_____

_____

_____

☐ Current Allergies _____

CURRENT MEDICATIONS

Medication	Reason Taken	Dose	Start Date

MENTAL HEALTH HISTORY

(Please indicate with whom, period of time, and outcome)

☐ Treated on an OUTPATIENT basis for Emotional or Behavioral Difficulties:

Reason Treatment Sought	Provider	Dates of Treatment	Outcome

☐ Previous Evaluations (Under Type please indicate Psychiatric, Psychological, Neuropsychological, Education, Speech, OT etc.:

Reason Sought	Type	Evaluator	Date

☐ Treated on an INPATIENT basis for Emotional or Behavioral Difficulties:

Reason Treatment Sought	Provider	Dates of Treatment	Outcome

☐ Currently prescribed Medication for Emotional or Behavioral Difficulties:

Medication	**Reason Taken**	**Dose**	**Start Date**

☐ Has experienced or witnessed traumatic event/s _____
_____
_____
_____

☐ Has been or suspect emotional, physical, or sexual abused/molested: _____
_____
_____
_____

Do you own firearms ☐Yes ☐No Are those firearms in your home ☐Yes ☐No Are your firearms secure ☐Yes ☐No
How do you like to use your firearms_____

SUBSTANCE USE HISTORY

I started drinking at age: ☐ less than 10 yrs old ☐ 10-15 ☐ 16-19 ☐ 20-21 ☐ over 21

I drink alcohol: ☐ rarely or never ☐ 1-2 days a week
☐ 3-5 days a week ☐ daily

Preferred type of drink_____

Usual Number of drinks I have on one occasion_____

My last drink was: ☐ less than 24 hours ago ☐ 24-48 hours ago
☐ over 48 hours ago ☐ I used to drink but stopped. Date ____/____/____

Check all that apply:

☐ I can drink more than most people my age and size before becoming drunk_____

☐ My drinking has/is creating problems for me (home life, legal, work, social) _____

☐ I sometimes blackout after drinking_____

☐ My drinking has affected my job/work performance_____

☐ I have driven while intoxicated_____

☐ I have been charged with a DUI or DWI_____

Do you consider yourself dependent on alcohol ☐ Yes ☐ No If yes, Why_____

_____

Please check all of the drugs that you are using or have used in the past:

	Presently Using	**Past**
Amphetamines (including diet pills)	☐	☐
Barbiturates (downers, etc.)	☐	☐
Cocaine or crack	☐	☐
Hallucinogenics (LSD, acid STP, etc.)	☐	☐
Inhalants (glue nitrous oxide etc.)	☐	☐
Marijuana	☐	☐
Opiate narcotics (heroin, morphine, etc.)	☐	☐
PCP (angel dust)	☐	☐
Others (please list)	☐	☐

_____

_____

Check all that apply:

☐ My drug use has/is creating problems for me (home life, legal, work, social) _____

☐ My drug use has affected my job/work/school performance_____

☐ I have driven while under the influence of drugs_____

☐ I have been through drug treatment_____

☐ I have gone through withdrawal_____

Do you consider yourself dependent on drugs ☐ Yes ☐ No If yes, Why_____

_____

Do you consider yourself dependent on prescription drugs ☐ Yes ☐ No If yes, Why_____

_____

Do you smoke cigarettes ☐ Yes ☐ No How many per day _____

Do you drink caffeinated beverages ☐ Yes ☐ No How many per day _____ What kind_____

FAMILY HISTORY - BIOLOGICAL MOTHER

Is your mother alive ☐ Yes ☐ No If no of what was the cause of her death_____ _____

School–highest grade completed or degree attained _____

Check all that apply:
☐ Learning problems–specify _____
☐ Behavior problems–specify _____
☐ Medical problems–specify _____
☐ Emotional problems–specify _____
☐ Neurological problems–specify _____
☐ History of alcohol abuse–specify _____
☐ History of drug use–specify _____
☐ Have any of your blood relatives ever had problems similar to yours? If so, describe._____

_____

_____

FAMILY HISTORY - BIOLOGICAL FATHER

Is your father alive ☐ Yes ☐ No If no what was the cause of his death_____
School–highest grade completed or degree attained _____
Check all that apply:
☐ Learning problems–specify _____
☐ Behavior problems–specify _____
☐ Medical problems–specify _____
☐ Emotional problems–specify _____
☐ Neurological problems–specify _____
☐ History of alcohol abuse–specify _____
☐ History of drug use–specify _____
☐ Have any of your blood relatives ever had problems similar to yours? If so, describe._____

_____

_____

FAMILY HISTORY - SIBLINGS

(Please provide a brief description.)

Name	Age	Medical, Social, Academic, or Behavioral Problems

ACADEMIC/EDUCATIONAL HISTORY

School/Institution Attended	Years Attended	Grades (A/B, B/C, C/D)	Degree Obtained
Elementary			
Middle			
High School			
College			
Grad School			
Trade School			

To the best of your knowledge, did you have trouble with any of the following?

	Above Grade Level	At Grade Level	Below Grade Level
Reading	☐	☐	☐
Spelling	☐	☐	☐
Arithmetic	☐	☐	☐

☐ Repeated a grade. If so, when & why_____

_____

☐ Skipped a grade. If so, when & why_____

_____

☐ Special class/school placement–specify _____

_____

☐ Resource assistance–specify_____

_____ ☐ IEP If so why, and what for_____

☐ 504 Plan If so what accommodations_____

Describe briefly any academic school problems that would help me to understand your school history_____

_____

_____

_____

OCCUPATIONAL HISTORY

(Please provide a brief description.)

Job/Company	Age	Dates	Reason for Leaving

MILITARY SERVICE

Served in the military? ☐ Yes ☐ No If so, which branch _____
For how long? _____ What rank were you able to achieve? _____

Did you ever experience combat ☐ Yes ☐ No

If so, have you experienced any difficulties either physical or psychological from the experience ☐ Yes ☐ No
If yes, please briefly describe_____
_____
_____
_____

Have you been discharged from the service? ☐ Yes ☐ No If so, with what type of discharge? _____

Did you serve in a reserve or guard unit? ☐ Yes ☐ No Do you continue to serve in a reserve or guard unit? ☐ Yes ☐ No

Additional Remarks About Educational/Occupational/Military – Please use the remainder of this page to write any additional comments you wish to make about these 3 areas of your life.

_____
_____
_____
_____
_____
_____
_____
_____

PROBLEM CHECKLIST

Most people exhibit, at one time or another, one or more of the symptoms listed below. Only mark those symptoms that have been present to a significant degree over a period of time.

Past	Current		Past	Current	
☐	☐	Feelings of sadness/blues	☐	☐	Lack of interest in normal activities
☐	☐	Feelings of discouragement/hopelessness	☐	☐	Lack of interest in sexual activities
☐	☐	Low self-esteem	☐	☐	Excessive self criticism
☐	☐	Depression	☐	☐	Frequent crying spells
☐	☐	Suicidal preoccupation/gestures/attempts	☐	☐	Frequently feels worthless
☐	☐	Suicidal thoughts	☐	☐	Poor motivation
☐	☐	Loss of interest in activities	☐	☐	Apathy
			☐	☐	Irritability–easily “flies off the handle”
Past	**Current**		**Past**	**Current**	

Past	Current		Past	Current	
☐	☐	Little concern for personal appearance/ hygiene	☐	☐	Significant weight gain
☐	☐	Low energy level	☐	☐	Feeling overwhelmed
☐	☐	Little concern/pride for personal property	☐	☐	Increase/decrease in appetite
☐	☐	Awakens in the middle of the night and has trouble falling asleep	☐	☐	Poor self image
			☐	☐	Nightmares
☐	☐	Anxiety attacks with heart palpitations, shortness of breath, sweating, etc.	☐	☐	Sudden/unexpected panic
			☐	☐	Sense of impending doom
☐	☐	Worry a lot	☐	☐	Frequent nausea/vomiting
☐	☐	Very tense	☐	☐	Hair pulling with hair loss
☐	☐	Insomnia (difficulty falling asleep)	☐	☐	Picks on skin
☐	☐	Excessive guild over minor indiscretions	☐	☐	Worries over body illness
☐	☐	Feeling tense/stressed/uptight/on edge	☐	☐	Nail biting, chews on clothes, etc.
☐	☐	Feeling detached from all/part of your body	☐	☐	Racing thoughts
☐	☐	Feeling things around you are unreal/ foggy/strange	☐	☐	Feeling dizzy/light headed
			☐	☐	Repetitive thoughts
☐	☐	Often complain/experience aches/pains	☐	☐	Fears of looking foolish in front of others
☐	☐	Perfectionistic, rarely satisfied	☐	☐	Repetitive physical actions
☐	☐	Feeling as if you are going to loose control	☐	☐	Difficulty concentrating
Fears					
☐	☐	Driving	☐	☐	New situations
☐	☐	Strangers	☐	☐	Being alone
☐	☐	Death	☐	☐	Heights
☐	☐	Flying	☐	☐	Animals
☐	☐	Other fears_____ _____	☐	☐	Being out of the home
☐	☐	Ticks (eye blinking, grimacing or other spasmodic repetitious movements	☐	☐	Involuntary grunts/vocalizations (understandable or not)
☐	☐	Eating binges with overweight	☐	☐	Overeating with overweight
☐	☐	Preoccupied with being overweight	☐	☐	Preoccupied with food
☐	☐	Dissatisfaction with appearance/body part/s	☐	☐	Under eating with underweight
☐	☐	Eats large amounts of food then vomits or uses laxatives	☐	☐	Long period of dieting and food abstinence with underweight
☐	☐	Long periods of exercise/over exercise to the point of physical pain			
☐	☐	Few if any friends	☐	☐	Doesn't seek/want relationships
☐	☐	Rarely sought out by peers	☐	☐	Not accepted by peer group
☐	☐	Feels awkward in social situations	☐	☐	Feels uncomfortable in social groups
☐	☐	Feels picked on by others	☐	☐	Would rather be alone than with others
☐	☐	Excessive modesty over body exposure	☐	☐	Shy
☐	☐	Fear asserting self	☐	☐	Gullible and/or naive
☐	☐	Frequently pouts and/or sulks	☐	☐	Inhibits open expression of anger
☐	☐	Allows self to be easily taken advantage of	☐	☐	Avoids jobs/activities that involve interaction with others
☐	☐	Inhibited by self expression in dancing, singing, laughing, etc	☐	☐	Fearful of being ashamed/ridiculed
			☐	☐	Fears taking risks may be embarrassing

☐	☐	Passive/easily led	☐	☐	Excessive demands for attention
☐	☐	Overly dependent on others	☐	☐	Others needs are more important
☐	☐	Excessive desire to please others	☐	☐	Always seeking a relationship
☐	☐	Without others feels helpless	☐	☐	Fear of disagreeing with others
☐	☐	Lacks self confidence to do something without another	☐	☐	Difficulty making everyday decisions without reassurance
☐	☐	Volunteers for unpleasant tasks to gain favor from others			
☐	☐	Suspicious/distrustful	☐	☐	Aloof
☐	☐	Feel others are persecuting me	☐	☐	Reluctant to confide in others for fear of being hurt
☐	☐	Often feels cheated/gypped			
☐	☐	Often doubts loyalty/trustworthiness of friends, family or associates	☐	☐	Often feel demeaned/threatened by others
☐	☐	Bears grudges			
☐	☐	Often engages in illegal activities	☐	☐	Often lies to others
☐	☐	Aggressive and have been involved in numerous arguments/fights	☐	☐	Often told by others you are irresponsible
			☐	☐	Disregard of the safety of others
☐	☐	Lack of remorse/indifference after hurting someone			
☐	☐	Often feels abandoned by others	☐	☐	Difficulty sustaining relationships with others
☐	☐	Lack of clear sense of self	☐	☐	Impulsivity
☐	☐	Suicidal gestures/behavior/acts	☐	☐	Unstable moods
☐	☐	Often feel empty	☐	☐	Difficulty controlling anger
☐	☐	Preoccupied with rules/details	☐	☐	Perfectionism interfere with tasks
☐	☐	Devoted to work at the exclusion of family/friends	☐	☐	Over conscientious
			☐	☐	Reluctant to delegate tasks
☐	☐	Unable discard worn out/worthless objects	☐	☐	Rigid
☐	☐	Miserly with money	☐	☐	Stubborn
☐	☐	Speaks rapidly and under pressure	☐	☐	Disorganized speech
☐	☐	Hears voices when no one is speaking	☐	☐	See visions
☐	☐	Often fantasizing, “live in your own world”	☐	☐	Disorganized behavior
☐	☐	Development of delusions, i.e., belief system that others have doesn’t make sense	☐	☐	Inappropriate emotional reactions
			☐	☐	Flat emotional tone
☐	☐	Difficulty sustaining attention while reading working or completing a task	☐	☐	Difficulty remembering short lists
			☐	☐	Difficulty completing tasks
☐	☐	Easily distracted	☐	☐	Trouble prioritizing work/tasks
☐	☐	Often procrastinate	☐	☐	Often make careless mistakes
☐	☐	Have trouble with time management	☐	☐	Mind often drifts off
☐	☐	Impulsively spend/engage in an activity	☐	☐	Difficulty organizing room, work area, etc.
☐	☐	Often miss parts of conversations with others	☐	☐	Often find self unprepared
☐	☐	Difficulty organizing a task	☐	☐	Often fidget/cannot sit still
☐	☐	Avoid engaging tasks requiring sustained mental effort	☐	☐	Difficulty waiting for my turn in line
			☐	☐	Often forgetful of daily activities
☐	☐	Often lose things	☐	☐	Often interrupt others

Past	Current		Past	Current	
☐	☐	Trouble with memory for recent events	☐	☐	Trouble recalling information just read
☐	☐	Feeling that mind is not as sharp as once was	☐	☐	Trouble recalling words
☐	☐	Feel I do not think as quickly as I once did	☐	☐	Difficulty recalling event of the previous day
☐	☐	Sexual difficulties			
☐	☐	Difficulty figuring out how to do new things	☐	☐	Difficulty planning ahead
☐	☐	Difficulty figuring out problems that most others can do	☐	☐	Difficulty thinking as quickly as needed
☐	☐	Feel I do not think as quickly as I once did	☐	☐	Difficulty completing an activity in a reasonable time
☐	☐	Difficulty finding the right word	☐	☐	Difficulty figuring out problems that most others can
☐	☐	Difficulty expressing thoughts			
☐	☐	Difficulty understanding what others say	☐	☐	Difficulty understanding what I read
☐	☐	Difficulty writing	☐	☐	Difficulty with math
☐	☐	Difficulty telling right from left	☐	☐	Forget where I am or where I am going
☐	☐	Difficulty doing things I should automatically be able to do (i.e., brushing my teeth)	☐	☐	Forget what I should be doing
			☐	☐	Forget recent events
☐	☐	Problems finding my way in familiar places	☐	☐	Forget where I leave things
☐	☐	Difficulty recognizing objects or people	☐	☐	Forget the order of events
☐	☐	Not aware of time	☐	☐	Forget facts but not how to do things
			☐	☐	Forget how to do things but not facts

Please indicate how your problems are affecting any of the following areas of you life–check and provide a brief explanation.

☐ School/Work _____

_____ ☐ Social Relationships _____

_____

☐ Family Relationships _____

_____

☐ Emotional Adjustment _____

_____ ☐ Physical Health _____

_____ ☐ Community/Legal _____

_____ ☐ Spiritual _____

_____

Additional Remarks– Please use the remainder of this page to write any additional comments you wish to make

_____

_____

_____

_____

_____

_____

_____

_____

R. Patrick Savage, Jr. Ph.D. ©Revised 9-17-17