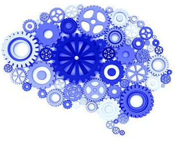

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ADULT INTAKE FORM

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: G Counseling G Evaluation G Psychological Testing G Neuropsychological Testing G Unsure

Person/s who referred you:___________________________________ Physician:____
Name Tel # Name Tel#
Medical Specialists: ____ May I contact physician to coordinate care: G Yes G No
____

FAMILY INFORMATION

Marital status: G Married G Separated G Divorced G Widowed G Other _________________________
Years Married _____________ Year of Marriage____________ Spouse's Health G Excellent G Good G Poor

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

G Accident____
G Hospitalization required____________________________________
G Poor Nutrition____
G Threatened miscarriage______________________________________
G Infection(s) (specify)___________________________________
G Toxemia/Preeclampsia____
G Operation(s) (specify)__________________________________
G Other illnesses) (specify)____________________________________
G Medications taken ______________________________________
G X-ray studies____
G Smoking :Ave cigarettes per day__________________________
G Alcoholic consumption beyond an occasional drink______________
G Drug Use:____
Activity level of fetus while in utero: G High G Medium G Low

Delivery

Type of labor: G Spontaneous G Induced G Emergency
Length of Pregnancy_________ Birth Weight_____________________
Type of delivery: GHeadfirst G Breech G Extremities G Cesarean____
Forceps: Ghigh______ G mid ______ G low______ Suction G Yes G No Duration of labor hours_______________________________
G Cord around neck_____________________________________
G Cord presented first____
G Hemorrhage____
G Fetal distress ____
G Placenta Previa______________________________________
G Other____
Respiration: G Immediate__________________________________
G Delayed (if so, how long)____________________________________
G Cyanosis (turned blue)__________________________________
G Mucus accumulation____
G Ingested Meconium_____________________________________
APGAR scores at delivery (if known): 1 minute______ 5 minutes_______
G Jaundice G Bilirubin Treatment (blue lights)–specify treatment length ____
G Rh factor G Transfusion G Injection ____
G Incubator–specify ____ # Days ______________________
G Intensive care–specify ____ # Days ______________________
G 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.

G Excessive restlessness ____
G Diminished sleep because of restlessness and easy arousal ____
G Constantly into everything ____
G Excessive number of accidents compared to other children ____
G Attentional Problems____
G Clumsiness____
G Muscle Weakness____
G Speech Problems____
G Hearing Problems____
G Vision Problems____
G Learning Disabilities____

DEVELOPMENTAL MILESTONES

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

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

COORDINATION

Rate your child on the following skills:

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

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.

G Childhood diseases (describe any complications) ____________________ ___
____________________G
Hospitalizations for illness (exclude operations) ____________________
____
G Hearing problems____________________
G EU tubes____________________
G Poisoning ____________________
G Surgery ____________________
____
G Head Injuries G with unconsciousness G without unconsciousness ____________________
____
G Sports Concussions/Injuries ____________________
G Convulsions G with fever ____________________ G without fever ____________________
G Coma ____________________
G Meningitis/encephalitis ____________________
G Involved in automobile accident ____________________
____
G Involved in work accident ____________________
____
G Surgeries____________________
____
G Seizures____________________
G Stroke ____________________
G Vision problems ____________________G Wears glasses/contacts ____________________
G Dementia____________________
G Arteriosclerosis____________________
G Heart Disease____________________
G Cancer____________________
G Allergies____________________
G Other ____________________

PRESENT MEDICAL STATUS

G Present illness(es) for which you are being treated____________________
____
____
____
G Current Allergies____________________

CURRENT MEDICATIONS

Medication	Reason Taken	Dose	Start Date

MENTAL HEALTH HISTORY

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

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

Reason Treatment Sought	Provider	Dates of Treatment	Outcome

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

Reason Sought	Type	Evaluator	Date

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

Reason Treatment Sought	Provider	Dates of Treatment	Outcome

G Currently prescribed Medication for Emotional or Behavioral Difficulties:

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

G Has experienced or witnessed traumatic event/s ____
____
____
____

G Has been or suspect emotional, physical, or sexual abused/molested: ______________________________
____
____
____

Do you own firearms GYes GNo Are those firearms in your home GYes GNo Are your firearms secure GYes GNo
How do you like to use your firearms____

SUBSTANCE USE HISTORY

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

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

Preferred type of drink____________________

Usual Number of drinks I have on one occasion______________

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

Check all that apply:

G I can drink more than most people my age and size before becoming drunk____________________
G My drinking has/is creating problems for me (home life, legal, work, social) ____________________
G I sometimes blackout after drinking____________________
G My drinking has affected my job/work performance____________________
G I have driven while intoxicated____________________
G I have been charged with a DUI or DWI____________________

Do you consider yourself dependent on alcohol G Yes G 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)	G	G
Barbiturates (downers, etc.)	G	G
Cocaine or crack	G	G
Hallucinogenics (LSD, acid STP, etc.)	G	G
Inhalants (glue nitrous oxide etc.)	G	G
Marijuana	G	G
Opiate narcotics (heroin, morphine, etc.)	G	G
PCP (angel dust)	G	G
Others (please list)	G	G

____
____

Check all that apply:

G My drug use has/is creating problems for me (home life, legal, work, social) ____________________
G My drug use has affected my job/work/school performance____________________
G I have driven while under the influence of drugs____________________
G I have been through drug treatment____________________
G I have gone through withdrawal____________________

Do you consider yourself dependent on drugs G Yes G No If yes, Why____________________
____

Do you consider yourself dependent on prescription drugs G Yes G No If yes, Why____________________
____

Do you smoke cigarettes G Yes G No How many per day ____________________

Do you drink caffeinated beverages G Yes G No How many per day __________ What kind____________________

FAMILY HISTORY - BIOLOGICAL MOTHER

Is your mother alive G Yes G No If no of what was the cause of her death__________ ____________________

School–highest grade completed or degree attained ____________________

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

FAMILY HISTORY - BIOLOGICAL FATHER

Is your father alive G Yes G No If no what was the cause of his death____________________
School–highest grade completed or degree attained ____________________
Check all that apply:
G Learning problems–specify ____________________
G Behavior problems–specify ____________________
G Medical problems–specify ____________________
G Emotional problems–specify ____________________
G Neurological problems–specify ____________________
G History of alcohol abuse–specify ____________________
G History of drug use–specify ____________________
G 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	G	G	G
Spelling	G	G	G
Arithmetic	G	G	G

G Repeated a grade. If so, when & why____
____

G Skipped a grade. If so, when & why____
____

G Special class/school placement–specify ____
____

G Resource assistance–specify____
____ G IEP If so why, and what for____

G 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? G Yes G No If so, which branch ____
For how long? _________________________ What rank were you able to achieve? __________________________

Did you ever experience combat G Yes G No

If so, have you experienced any difficulties either physical or psychological from the experience G Yes G No
If yes, please briefly describe____
____
____
____

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

Did you serve in a reserve or guard unit? G Yes G No Do you continue to serve in a reserve or guard unit? G Yes G 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	
G	G	Feelings of sadness/blues	G	G	Lack of interest in normal activities
G	G	Feelings of discouragement/hopelessness	G	G	Lack of interest in sexual activities
G	G	Low self-esteem	G	G	Excessive self criticism
G	G	Depression	G	G	Frequent crying spells
G	G	Suicidal preoccupation/gestures/attempts	G	G	Frequently feels worthless
G	G	Suicidal thoughts	G	G	Poor motivation
G	G	Loss of interest in activities	G	G	Apathy
			G	G	Irritability–easily “flies off the handle”
Past	**Current**		**Past**	**Current**	

G G Little concern for personal appearance/ hygiene
G G Low energy level
G G Little concern/pride for personal property
G G Awakens in the middle of the night and has trouble falling asleep

G G Anxiety attacks with heart palpitations, shortness of breath, sweating, etc.
G G Worry a lot
G G Very tense
G G Insomnia (difficulty falling asleep)
G G Excessive guild over minor indiscretions
G G Feeling tense/stressed/uptight/on edge
G G Feeling detached from all/part of your body
G G Feeling things around you are unreal/ foggy/strange
G G Often complain/experience aches/pains
G G Perfectionistic, rarely satisfied
G G Feeling as if you are going to loose control

Fears

G G Driving
G G Strangers
G G Death
G G Flying
G G Other fears______________________________
____

G G Ticks (eye blinking, grimacing or other spasmodic repetitious movements

G G Eating binges with overweight
G G Preoccupied with being overweight
G G Dissatisfaction with appearance/body part/s
G G Eats large amounts of food then vomits or uses laxatives
G G Long periods of exercise/over exercise to the point of physical pain

G G Few if any friends
G G Rarely sought out by peers
G G Feels awkward in social situations
G G Feels picked on by others

G G Excessive modesty over body exposure
G G Fear asserting self
G G Frequently pouts and/or sulks
G G Allows self to be easily taken advantage of
G G Inhibited by self expression in dancing, singing, laughing, etc

Past Current

G G Significant weight gain
G G Feeling overwhelmed
G G Increase/decrease in appetite
G G Poor self image

G G Nightmares
G G Sudden/unexpected panic
G G Sense of impending doom
G G Frequent nausea/vomiting
G G Hair pulling with hair loss
G G Picks on skin
G G Worries over body illness
G G Nail biting, chews on clothes, etc.
G G Racing thoughts
G G Feeling dizzy/light headed
G G Repetitive thoughts
G G Fears of looking foolish in front of others
G G Repetitive physical actions
G G Difficulty concentrating

G G New situations
G G Being alone
G G Heights
G G Animals
G G Being out of the home

G G Involuntary grunts/vocalizations (understandable or not)

G G Overeating with overweight
G G Preoccupied with food
G G Under eating with underweight
G G Long period of dieting and food abstinence with underweight

G G Doesn't seek/want relationships
G G Not accepted by peer group
G G Feels uncomfortable in social groups
G G Would rather be alone than with others

G G Shy
G G Gullible and/or naive
G G Inhibits open expression of anger
G G Avoids jobs/activities that involve interaction with others
G G Fearful of being ashamed/ridiculed
G G Fears taking risks may be embarrassing

Past Current

G G Passive/easily led
G G Overly dependent on others
G G Excessive desire to please others
G G Without others feels helpless
G G Lacks self confidence to do something without another
G G Volunteers for unpleasant tasks to gain favor from others

G G Suspicious/distrustful
G G Feel others are persecuting me
G G Often feels cheated/gypped
G G Often doubts loyalty/trustworthiness of friends, family or associates
G G Bears grudges

G G Often engages in illegal activities
G G Aggressive and have been involved in numerous arguments/fights
G G Lack of remorse/indifference after hurting someone

G G Often feels abandoned by others
G G Lack of clear sense of self
G G Suicidal gestures/behavior/acts
G G Often feel empty

G G Preoccupied with rules/details
G G Devoted to work at the exclusion of family/friends
G G Unable discard worn out/worthless objects
G G Miserly with money

G G Speaks rapidly and under pressure
G G Hears voices when no one is speaking
G G Often fantasizing, “live in your own world”
G G Development of delusions, i.e., belief system that others have doesn’t make sense

G G Difficulty sustaining attention while reading working or completing a task
G G Easily distracted
G G Often procrastinate
G G Have trouble with time management
G G Impulsively spend/engage in an activity
G G Often miss parts of conversations with others
G G Difficulty organizing a task
G G Avoid engaging tasks requiring sustained mental effort
G G Often lose things

G G Excessive demands for attention
G G Others needs are more important
G G Always seeking a relationship
G G Fear of disagreeing with others
G G Difficulty making everyday decisions without reassurance

G G Aloof
G G Reluctant to confide in others for fear of being hurt
G G Often feel demeaned/threatened by others

G G Often lies to others
G G Often told by others you are irresponsible
G G Disregard of the safety of others

G G Difficulty sustaining relationships with others
G G Impulsivity
G G Unstable moods
G G Difficulty controlling anger

G G Perfectionism interfere with tasks
G G Over conscientious
G G Reluctant to delegate tasks
G G Rigid
G G Stubborn

G G Disorganized speech
G G See visions
G G Disorganized behavior
G G Inappropriate emotional reactions
G G Flat emotional tone

G G Difficulty remembering short lists
G G Difficulty completing tasks
G G Trouble prioritizing work/tasks
G G Often make careless mistakes
G G Mind often drifts off
G G Difficulty organizing room, work area, etc.
G G Often find self unprepared
G G Often fidget/cannot sit still
G G Difficulty waiting for my turn in line
G G Often forgetful of daily activities
G G Often interrupt others

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

G School/Work____

____ G Social Relationships ____

____

G Family Relationships ____

____

G Emotional Adjustment____

____G Physical Health ____

____G Community/Legal____

____G Spiritual ____

____

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

____

____

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