Patient Name: _____ Patient Date of Birth: _____

Adult New Patient Clinical Intake Form

Thank you for taking the time to complete this document. This history form is designed to give you an opportunity to provide us with a wide variety of background information. Please read the questions carefully and answer them as frankly as possible. The information will help us to help you. Completion of this form is considered the first step in the evaluation and treatment process. By answering these questions in advance, our staff will be able to spend more time during the initial interview discussing the issues that are most important to you, as you begin or continue mental health treatment.

Date you are completing this form: _____

Please list all medications (prescriptions, over-the-counter, herbals or supplements) you are using now**, including dosages and times** you take the medications:

If you have any **ALLERGIES** or have had bad reactions to any medications, please list them here and describe the reaction:

Please list the name(s), address(es), and phone numbers of your **primary care provider(s)** or clinic(s) you use most often:

Please list the names and addresses of **any other doctors you are seeing/have seen**:

1.

2.

3.

Please give the name, address, and phone number of the **pharmacy you prefer** to use:

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MEDICAL HISTORY

Please check all of these that you have now and/or have had in the past. If it occurred in the past, please indicate the age when it was happening.

Pres.	Past	Age		Pres.	Past	Age	
_____	_____	_____	crying spells	_____	_____	_____	arthritis
_____	_____	_____	head injury	_____	_____	_____	asthma
_____	_____	_____	headaches	_____	_____	_____	back problems
_____	_____	_____	fainting / dizziness	_____	_____	_____	bed-wetting / soiling
_____	_____	_____	seizures	_____	_____	_____	bladder problems
_____	_____	_____	unconsciousness	_____	_____	_____	bowel problems
_____	_____	_____	loss of appetite	_____	_____	_____	cancer
_____	_____	_____	weight gain / loss	_____	_____	_____	diabetes
_____	_____	_____	high fevers	_____	_____	_____	heart trouble
_____	_____	_____	hives / rashes	_____	_____	_____	hepatitis / jaundice
_____	_____	_____	blood pressure (high / low)	_____	_____	_____	kidney trouble
_____	_____	_____	chest pain / pressure	_____	_____	_____	liver trouble
_____	_____	_____	shortness of breath	_____	_____	_____	rheumatic fever
_____	_____	_____	gynecological problem	_____	_____	_____	stomach problems
_____	_____	_____	premenstrual syndrome	_____	_____	_____	stroke
_____	_____	_____	nightmares	_____	_____	_____	thyroid problems
_____	_____	_____	night sweats	_____	_____	_____	tuberculosis
_____	_____	_____	pos. test for AIDS antibody	_____	_____	_____	unusual bleeding
_____	_____	_____	sexual dysfunction	_____	_____	_____	other _____
_____	_____	_____	skin problems	_____	_____	_____	other _____

Please use this area to comment on any of the items listed above, and on any other serious accidents, operations, or illnesses:

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MENTAL HEALTH HISTORY

What mental health or psychiatric conditions have you been diagnosed with in the past (list diagnosis and date you were first diagnosed):

If you have **a current** Psychiatrist and/or Counselor / Therapist, please list below:

Psychiatrist: location and phone number:

Therapist: location and phone number:

If you have ever seen a mental health provider in the **past** (psychiatrist, psychologist, social worker, counselor, member of the clergy, family doctor, etc.) for this, or for similar problems, please list the following:

Professional's Name/Address Dates seen (from _____/to _____) Problem

1.
2.
3.
4.
5.

If you have ever been **hospitalized** for psychiatric or medical conditions, please list the following:

Hospital's Name/Address Dates seen (from _____/to _____) Problem

1.
2.
3.
4.

If you have had prior mental health treatment, what type of therapy, services, and/or medications did you find to be the **most helpful**?

What new approaches or services do you feel would be of the most help to you, if those services are available? (specific therapies, respite care, support groups, drop-in-center, intensive case management, outpatient therapy, etc.)

Briefly describe the mental health reason(s) that brought you to our clinic today. The details of what has brought you in will be discussed with your clinician, so if possible, please attempt to summarize.

How long has this been a problem or when did it worsen?

What has made it better?

What has made it worse?

If you have ever used or tried any medications for mental health related problems (anxiety, depression, bipolar, psychosis, or others), please list them here and comment on the reason they were discontinued or any benefits/problems you had with them:

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Please check the following if it applies to you and describe details in the space provided:

_____ Sleep Difficulties
- _____ can't fall asleep
- _____ can't stay asleep through the night
- _____ wake up too early
- _____ sleeping too much

Details:

_____ Eating Difficulties
- _____ eating too much
- _____ eating too little
- _____ binge eating and/or purging

Details:

_____ Difficulties maintaining a daily routine

Details:

Please describe any especially frightening or disturbing events that you have experienced, such as automobile accidents, fires, deaths, violence, crime victimization, and illnesses:

Has anyone ever physically, emotionally, or verbally abused you? Yes ◯ No ◯

If you consume caffeine (in coffee, tea, colas, etc.), how much do you consume daily?

If you use tobacco, how much and what type do you use daily?

If you have ever used alcohol, when, where, how much, and what type do you (did you) drink?

If you have ever used street drugs (marijuana, cocaine, LSD, etc.) or abused prescription medications, please list the following:

Type of drug	Amount	Frequency	Most Recent Usage

If you have ever been **treated for substance abuse**, please list the name(s) and address(es) of the treatment sites(s):

	Name/Address	Dates (From /to)	Problem
1.			
2.			
3.			

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If you have ever been arrested, please check all that apply:

Juvenile arrest record	Yes ☐	No ◉
Adult arrest record	Yes ☐	No ◉
Currently on probation	Yes ☐	No ●
Currently on parole	Yes ☐	No ●

If on probation/parole, list the name, address, and phone number of the P.O.:

If applicable, please describe the arrest record here:

Do you have any history of aggressive behavior or legal / criminal charges related to assaults? Yes ◯ No ◯
If so, please describe:

FAMILY HISTORY

	Name	Age	Occupation	Lives in…(city/state)
Father				
Mother				
Brothers and sisters				

Please use this space to comment on your family while you were growing up, noting any rough spots, such as parental separation/divorce/remarriage, and if someone other than your natural parents raised you, note the name(s):

If you have lived in any foster homes or residential placements, please list the name(s) and address(es):

Check any of the following that occurred (or are occurring now) in your family and give a brief description of those checked in the space below:

1. Physical abuse _____
2. Violent arguments/fighting _____
3. Child abuse _____
4. Sexual abuse _____
5. Chronic illness _____
6. Alcohol abuse _____
7. Drug abuse _____
8. Suicidal behavior _____
9. Involvement with a cult _____
10. Involvement with a gang _____

If any members of your family have been treated for mental or emotional problems, or substance abuse issues, please explain the circumstances here:

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MARITAL AND SOCIAL HISTORY

Current Relationship Status (please circle):

Single Married Living with Someone Separated Divorced Widowed Other - _____

Please provide some information about your past and present relationships with others and note any current relationship problems you may be having:

If you have children, please list the following information:

Name	Age	Lives with…	School grade/occupation

Please list the names, ages, and relationships to you of those currently living with you and not listed above, including all family members, friends, and so on.

Name	DOB/Age	Relationship

Please check what language(s) is (are) spoken and/or written in your home?

English: ☐ spoken ☐ written

Spanish: ☐ spoken ☐ written

Other Language(s): _____ ☐ spoken ☐ written

Do you consider yourself spiritual and/or religious? Yes No . If you are actively involved in church, temple, mosque, or other spiritual activities, please give the name of this organization and a brief description of the activities:

Do you feel you make friends easily? Yes ☐ No ☐

Do you feel that you generally trust people fairly easily? Yes ☐ No ☐

Briefly describe any difficulties you may have in dealing with people:

What do you enjoy doing in your spare time? Include hobbies, interests, and anything else that helps you relax.

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EDUCATIONAL HISTORY

What is the furthest you have gone in school? _____ GED? Yes ____ No ____

	School Name	City, State	Degree, if one obtained	Year graduated or ended
High School				
College				
Grad School				
Other Specialized Training or Education				

If you had any trouble in school with either academic subjects or behavior, or any know learning or developmental delays/concerns please describe the problem(s) here:

If you received any special awards or honors in school, please note them here:

OCCUPATIONAL HISTORY

Present occupation & employer: _____

How long have you had this job? _____

Please describe the nature of your duties/responsibilities and note any recent changes that have been stressful (include promotions, demotions, awards, or any disciplinary actions):

If your current mental health problems or medications are interfering with job performance, please comment upon that here:

How well do you get along with fellow workers? _____

How well do you get along with supervisor(s)? _____

How many different jobs have you held in the last five years? _____

What other jobs have you held since you began working?

Please list any specialized job training you have received or skills you have mastered:

How would you describe yourself in relationship to spending, saving, and managing money?

Who is aware you are beginning mental health services? (e.g. family, friends, and/or employer)

If others are aware, what is their attitude about it?

What strengths can you list that will help in resolving the issues you have noted? (e.g., family supports, friendships, personal insights, faith, etc.)

Please explain what type(s) of transportation you use: (Do you drive, take buses, or have other transportation available?)

If someone helped you fill out this form, please write his or her name and phone number here:

Please review your answers and, if there is anything else you feel would be important, please include it here:

Thank you for taking the time to fill out this form.