Adult Intake Form

Name _____

Date of Birth_____ Gender _____

Address _____

Home Phone _____ Email _____

Primary Care Physician _____ Phone _____

Therapist _____ Phone _____

Insurance _____

Please provide a brief description of your concerns and/or reason for visit:

_____

_____

_____

PSYCHIATRIC HISTORY

Psychiatric Medications – List ALL current and previous psychiatric medications

Medication Dose & Name	Reason Prescribed	Side Effects?

Have you seen a psychiatrist in the past? __ Yes __ No If yes, please complete the following:

Psychiatrist Name	When Seen	Reason/Diagnoses

Have you been psychiatrically hospitalized? __ Yes __ No If yes, please complete the following:

Hospital Name	When	Reason/Diagnoses

Are there any guns or other weapons in the home? __ Yes __ No

MEDICAL HISTORY

Do you have any health problems?

_____

_____

Are you allergic to any medications? __ Yes __ No Is yes, please list: _____

Have you had any surgeries in the past? __ Yes __ No If yes, please list what and when:

_____

_____

Please list any prescribed medications you take

Medication Dose & Name	Frequency	Reason Prescribed

Please list any vitamins, minerals or other non-prescription medications and/or supplements

Medication Dose & Name	Reason Prescribed	Side Effects?

SOCIAL HISTORY

Current Occupation/Source of Income: _____

Highest Level of Education: _____

Are you currently: __ Single __ Married __Domestic Partners __ Separated __ Divorced

How long/please describe? _____

Please list other individuals (children, parents, etc.) residing in the home and their relationship to you.
_____

_____

_____

Has you ever been:
Arrested __ Yes __ No On probation? __ Yes __ No Charged with a crime? __ Yes __ No

If yes, please describe: _____

Substance Use History

Drug Type/Name	Age of First Use	Largest Amount Used	Current Amount & Frequency	Last Use	Never Used
Tobacco					
Alcohol					
Marijuana					
Heroin					
Cocaine					
Prescription Medications					
Other					

FAMILY HISTORY

Please indicate any mental health history in each of the child's biological or blood relatives

			Father's Family			Mother's Family	
	Siblings	Father	Aunts/ Uncles	Grand parents	Mother	Aunts/ Uncles	Grand parents
Depression							
Anxiety							
OCD							
Bipolar Disorder							
Schizophrenia							
ADHD							
Learning problems							
Autism Spectrum Disorder							
Substance Use							
History of suicide attempts							