INSIGHTS COLLABORATIVE THERAPY GROUP

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ADULT INTAKE FORM

Welcome to Insights. We realize that seeking help from a mental health professional is often a difficult decision. We recognize and applaud your courage and willingness.

This form asks for information about you so Insights can craft your therapy to be as effective and efficient as possible. Some questions are personal and may be sensitive or even uncomfortable for you. They are asked in an effort to quickly begin building a complete picture of who you are, which in turn will save valuable therapy time. All client records are strictly confidential and will not be seen by anyone without your written permission unless required by law. If you have any questions, please discuss them with your therapist.

Name ______________________________ Occupation: ____________________________

Address: ______________________________ Employer: ____________________________

City, State, Zip: ______________________________ Employed: ☐Full time ☐Part time

Home Phone: _____________________________ Student: ☐Full time ☐Part time

Cell Phone: _____________________________ Email address: _________________________

Date of Birth: _____________________________ Age: _________________________________

Contact Permissions

May we call you at home ☐Yes ☐ No

May we call you at work ☐Yes ☐No

May we call you by cell phone ☐Yes ☐No

May we text your cell phone? ☐Yes ☐No

May we leave you a message at home ☐Yes ☐No

May we leave you a message at work ☐Yes ☐No

May we leave you a message on cell phone ☐Yes ☐No

May we email you? ☐Yes ☐No

Please keep in mind that communications by email or text are not secure. Although unlikely, there is a possibility that information included in an email or text can be intercepted and read by other parties besides the person to whom it is addressed.

SOCIAL INFORMATION

Relationship status

- [ ] Married
- [ ] Divorced
- [ ] Significant Other
- [ ] Separated
- [ ] Living Together
- [ ] Widowed
- [ ] Single (never in a relationship)
- [ ] Single (not currently in a relationship)
- [ ] Other ____

Relationship satisfaction

- [ ] Very satisfied
- [ ] Satisfied
- [ ] Somewhat satisfied
- [ ] Dissatisfied
- [ ] Very dissatisfied
- [ ] Not in a relationship

Children

- [ ] None
- [ ] Child 1 (specify name, gender, age and with whom child lives _______________________________________ ____)
- [ ] Child 2 (specify name, gender, age and with whom child lives _______________________________________ ____)
- [ ] Child 3 (specify name, gender, age and with whom child lives _______________________________________ ____)
- [ ] Child 4 (specify name, gender, age and with whom child lives _______________________________________ ____)
- [ ] Child 5 (specify name, gender, age and with whom child lives _______________________________________ ____)

Number of marriages or significant relationships

- [ ] Marriages ________________________
- [ ] Significant relationships _____________

What is your current occupation? How long have you been doing it? ____________________________

____

Education (highest achieved)

- [ ] Grade school/junior high
- [ ] Attending/attended high school
- [ ] High school graduate
- [ ] Attended/attending college
- [ ] College graduate
- [ ] Attended/attending graduate school
- [ ] Graduate degree (Masters)
- [ ] Graduate degree (Doctorate)
- [ ] Technical school degree

Sexual orientation ____

Cultural or ethnic identity claimed ____

Religious orientation (if any) as a child ____

Religious orientation (if any) as an adult ____

Military service

- ☐ None
- ☐ Branch
- ☐ Years served
- ☐ Combat
- ☐ Type of discharge ____________________

Arrests, convictions, court-orders, parole, probation, or jail or prison sentences, if any

- ☐ Yes (specify ____)
- ☐ No

Current living situation

- ☐ Alone
- ☐ With others
- ☐ Anything others might find unusual about your living arrangements (specify ______________________

____)

Please tell us anything we have not asked that you think is important for us to know about you. ___________

____

____

SPOUSE/PARTNER CONTACT INFORMATION

Spouse/partner contact information

- ☐ Name ____
- ☐ Home Address_____________________________________
- ☐ Home Phone ______________________________________
- ☐ Cell phone ____
- ☐ Employer ____
- ☐ Occupation____
- ☐ Relationship _______________________________________

WHAT BRINGS YOU TO INSIGHTS

Who referred you to Insights?

Name: _________________________________

Phone: _________________________________

May we contact that person to say thank you? □Yes □No

Briefly describe what brings you to Insights. ____

____

How concerned are you about the problem(s) that brings you to Insights?

- ☐ No concern
- ☐ Slight concern
- ☐ Moderate concern
- ☐ Serious concern
- ☐ Very serious concern

What is your motivation for coming to Insights?

- ☐ Self-motivated
- ☐ Other-motivated

If you were motivated to come to Insights by someone or something else, what was the motivation?

- ☐ Threat of spouse or partner leaving
- ☐ Keep job
- ☐ Stay in school
- ☐ Live at home
- ☐ Keep professional license
- ☐ Child custody is a significant factor
- ☐ Condition of probation or parole
- ☐ Other __________________________

What do you hope to accomplish in therapy? ____

____

Have you been in counseling or therapy with a mental health professional before, either alone or with someone else?

- ☐ Yes (specify and was it helpful? ____

____)

- ☐ No

Insights is a training facility. Do you consent for a Masters or Ph.D. level Intern sit in on your sessions from time to time?

- ☐ Yes
- ☐ No
- ☐ Willing to discuss

MEDICAL/EMOTIONAL INFORMATION

Date of your last physical ____

Who is your primary care physician?

- ☐ Name and phone number ____

- ☐ If we think it is appropriate, may we contact him or her? ☐Yes ☐No

- ☐ I don’t have one

Who is your psychiatrist?

☐ Name and phone number ____

☐ If we think it is appropriate, may we contact him or her? □Yes □No

☐ I don't have one

Have you ever been hospitalized for a psychiatric or mental health issue?

☐ Yes (specify where, when and why____

____.)

☐ No

Do you have learning differences or disabilities?

☐ Yes (specify ____

____)

☐ No

For each medication you currently take (prescribed, non-prescribed and recreational), specify medication name, dosage, purpose, date started, name of prescribing physician or psychiatrist

____

____

____

____

____

Symptoms (check any symptoms that apply to you)

☐ Aggression
☐ Alcohol abuse
☐ Anger
☐ Antisocial behavior
☐ Anxiety
☐ Avoiding people/isolation
☐ Chest pain
☐ Depression
☐ Disorientation
☐ Distractibility
☐ Mood shifts
☐ Eating disorder
☐ Racing thoughts
☐ Fatigue
☐ Hallucinations
☐ Heart palpitations
☐ High blood pressure
☐ Hopelessness
☐ Impulsivity
☐ Irritability
☐ Judgment errors
☐ Loneliness
☐ Memory impairment
☐ Drug abuse
☐ Phobias/fears
☐ Sexual difficulties
☐ Sick often
☐ Sleeping problems
☐ Suicidal thoughts
☐ Thoughts disorganized
☐ Trembling
☐ Withdrawing
☐ Worrying
☐ Dizziness
☐ Panic attacks
☐ Elevated mood
☐ Decreased appetite
☐ Increased appetite
☐ Trouble concentrating
☐ Low motivation
☐ Tearful or crying spells
☐ Poor grooming
☐ Other ________________

Specify all medical treatments, procedures, and operations you have had within the last year.

____

____

____

Women

- ☐ Age at first period (specify______)
- ☐ Are your periods regular □Yes □No
- ☐ Do your periods affect your mood
- ☐ Menopause □Yes □No
- ☐ Perimenopause □Yes □No
- ☐ Hormone replacement □Yes □No
- ☐ Number of pregnancies (specify______)
- ☐ Number of miscarriages (specify______)
- ☐ Number of abortions (specify______)

Which of the following have you used in the past year?

- ☐ Alcohol
- ☐ Amphetamines (meth, crank, ice, etc.)
- ☐ Crack
- ☐ Hallucinogens (LSD, mushrooms, etc.)
- ☐ Inhalants
- ☐ Marijuana
- ☐ Opiates (heroin, oxy, Vicodin, etc.)
- ☐ Sedatives
- ☐ Tranquillizers (Valium, Xanax, etc.)
- ☐ Designer drugs (X, GHB, etc.)
- ☐ Over the Counter
- ☐ ADD medications (Adderall, Vyvanse, etc.)
- ☐ Other (specify_____________________________)
- ☐ None

Have you or others ever been concerned about your alcohol or substance use?

- ☐ Yes (specify who has been concerned____)
- ☐ No

Have you ever lost a friendship, relationship or job because of your alcohol or substance use?

- ☐ Yes
- ☐ No

Do you have suicidal thoughts?

- ☐ Yes (describe____)
- ☐ No

Have you ever attempted suicide?

- ☐ Yes (when____)
- ☐ No

Do you have thoughts or urges to harm others?

- ☐ Yes (describe____)
- ☐ No

Have you ever had a head injury resulting in loss of consciousness?

- ☐ Yes (describe____)
- ☐ No

Is there a history of mental illness in your family?

- ☐ Yes (describe____)
- ☐ No

Have you ever had a seizure?

- ☐ Yes (describe____)
- ☐ No

On average, how many hours of sleep do you get daily? ____

Do you have trouble falling asleep at night?

- ☐ Yes
- ☐ No

Have you lost or gained over ten pounds in the past year?

- ☐ Yes (specify intentional or unintentional ____)
- ☐ No

How often do any of these thoughts occur to you?

- ☐ Life is hopeless
- ☐ I am lonely
- ☐ No one cares about me
- ☐ I am a failure
- ☐ Most people don't like me
- ☐ I want to die
- ☐ I want to hurt someone
- ☐ I am so stupid
- ☐ I am going crazy
- ☐ I can't concentrate
- ☐ I am so depressed
- ☐ God is disappointed in me
- ☐ I can't be forgiven
- ☐ Why am I so different
- ☐ I can't do anything right
- ☐ People hear my thoughts
- ☐ I have no emotions
- ☐ Someone is watching me
- ☐ I hear voices in my head
- ☐ I am out of control

Have you ever been the victim of abuse, violence or experienced a traumatic event?

- ☐ Yes (describe____)
- ☐ No

EMERGENCY CONTACT INFORMATION

Emergency contact information

- ☐ Name ________________________________
- ☐ Relationship ___________________________
- ☐ Home phone ___________________________
- ☐ Work phone ___________________________
- ☐ Cell phone ____________________________
- ☐ Permission to contact in case of emergency?
  ☐Yes ☐No