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Adult Patient Intake

Full Legal Name: _____

Date of Birth:_____/_____/_____ Age: _____ Race: _____ Sex: _____

Marital Status: _____No. of Times Married: _____

Children (names and ages): _____

Place of employment and position: _____

Live where and with whom (Names and relationships):

_____

Current hobbies or interests:_____

Religious/Spiritual Affiliation: _____ _____ No affiliation

Psychological and Behavioral Symptoms (Check all that apply)

- ○ Crying spells
- ○ Loss of interests in activities
- ○ Anger issues
- ○ Problems with sleep
- ○ Problems with appetite
- ○ Hopelessness/helplessness
- ○ Mood swings
- ○ Thoughts of dying/suicide
- ○ Injury/acts of harm to self
- ○ Thoughts of wanting to kill/homicide
- ○ Physical fatigue or discomfort
- ○ Arguments with family/partner/coworkers
- ○ Facing possible marital separation/divorce
- ○ Sexual problems
- ○ Worried thoughts
- ○ Panic attacks (racing heart rate, feeling of impending doom)
- ○ Phobias (intense fears of specific events or things)
- ○ Flashbacks of terrible events
- ○ Feeling "on top of the world" or "I can do anything"
- ○ Difficulty accepting changes
- ○ Self-esteem changes
- ○ Using alcohol or drugs to cope
- ○ Self-inflicting injury to relieve emtions
- ○ Other symptoms or changes in functioning:

_____

Medical History:

Current medical issues/concerns/physical complaints: _____

History of medical problems/surgeries: _____

Allergies: _____

Current medications and dosages (list prescription and over-the-counter): _____

_____

Date of most recent physical examination: _____

History of Psychological Symptoms/Treatment:

******Where treatment took place, how long it lasted, and outcome of services***

Inpatient and/or Partial Hospitalization:

Outpatient Therapy:

Substance Abuse Treatment:

Suicide Attempts:

History of medications for psychological symptoms:

Family history of suspected or diagnosed mental health issues:

Childhood/Family Events

Grew up where?

Who raised patient? Describe the(se) relationship(s):

Any developmental delays (sitting up, walking, talking, speech problems?):

History of physical abuse or neglect?

Domestic conflicts or violence in the home?

History of sexual abuse or rape/assault?

History of verbal abuse or being bullied?

Legal history or use of a weapon?

Education

Highest level of schooling completed: __ Some high school __HS Graduate: _____ College

Currently in school? _____ If so, where? _____

Any Special Needs or Special Education classes? _____

Expelled or suspended from school? Behavioral issues? How often and for what reason(s)? _____

Chemical Use History

	Age at first use	Date of most recent use	Current amount per sitting
Caffeine			
Nicotine			
Alcohol			
Marijuana			
Cocaine			
Crack Cocaine			
Ecstasy			
Heroine			
Barbiturates			
Crystal Meth			
Prescription or “over the counter”			
Other:			

Patient First and Last Name:

Describe family substance use/abuse history:

Want to cut down on drinking or drug/pill use? Yes No

Anyone ever express concern about alcohol or drug use? Yes No

History of use while driving? Yes No Had a black out? Yes No
If yes to either question, please describe:

Goal(s) for Treatment: 1:
2:

_____ Date: _____
Signature of Patient

_____ Date: _____
Rebecca Uppercue, LCSW
Licensed Clinical Social Worker

This section is for Office Use Only. Clinical Summary and Diagnoses:

Presentation/Mental Status:

Appearance:	well groomed	unkempt	imappropriate		
Mood/Emotion:	euthymic	depressed	irritable	manic	dysthymic
Affect:	appropriate	blunted	flat	euphoric	
Speech:	fluent	slowed	mute	loud	pressured
Cognition:	oriented x 5	distracted	confused	vigilant	disoriented
Insight:	good	poor	denial	disorted	
Memory:	normal	impaired			

Clinical Summary/Impression:

Treatment recommendations: IND/FAM sessions _____times per month to address symptoms using _____treatment strategies.

DSM-V Diagnosis:

_____ Date: _____
Rebecca Uppercue, LCSW
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