FAMILY PSYCHOLOGICAL RESOURCES
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Roswell, GA 30075
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Adult Clinical Intake Form

Note: If you were a patient here before, please fill in only the information that has changed.

Identification

Name____ Date______________________

Date of Birth____________________________________

Initial appointment date____________________________

Emergency Contact:

Name ________________________ Relationship____________Telephone___________

Marital Status_______________________________

By whom were you referred? ____

Chief concern

Please describe the main difficulty that has brought you to our office:

____

____

____

____

On the scale below please estimate the severity of your problem(s):

Mildly upsetting___ Moderately upsetting___ Very Severe___ Extremely severe___ Totally Incapacitating___

When did your problems begin (dates and/or significant events):_____________________

____

Medical History

Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E)

Age Illness/diagnosis Treatment received Treated by Result

____

____

____

____

____

____

Describe any allergies you have.
To what? Reaction Allergy medications you take

___
___
___

List ***all*** non-psychiatric medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.
Medication/drug Dose (how much?) Taken for Prescribed and supervised by

___
___
___
___
___
___

Your current family or personal physician or medical agency:
Name Specialty Address Phone # Date of last visit

___
___
___
___

Other physicians treating you at present or in last 5 years:
Name Specialty Address Phone # Date of last visit

___
___
___
___

Health habits
What kinds of physical exercise do you get?___
___

How much coffee, cola, tea, or other sources of caffeine do you consume each day?___
___
___

Do you try to restrict your eating in any way? How? Why? ___
___
___

Do you have any problems getting enough sleep? ___

For women only
At what age did you start to menstruate (get your period): ___

Menstrual period experiences:
How regular are they? ____
How long do they last? ____
How much pain do you have? _______________________________________
How heavy are your periods? _______________________________________
Other experiences during period? ____________________________________

Please list all of your pregnancies:

What happened with pregnancy?
Your age Miscarriage/Abortion/Child born Problems?
____
____
____
____
____

Menopause:
If your menopause has started, at what age did it start? ___________________
What signs or symptoms have you had? ________________________________
____

Other
Are there any other medical or physical problems you are concerned about? __________
____
____
____

Psychological/Psychiatric History
Have you ever received psychological or psychiatric or counseling services before? If yes, please indicate:
When? From whom? For what? With what results?
____
____
____
____

Have you ever taken medications for psychiatric or emotional problems? If yes, please indicate:
When? From whom? Which medications? For what? With what results?
____
____
____
____

Have your ever attempted suicide?____

Have you ever been hospitalized for a mental condition? If so, where and when?
Place Date

Has anyone in your family suffered from any "mental disorder"? If so, whom:

Work
What sort of work are you doing now? Does your present work satisfy you?

What kinds of jobs have you held in the past?

What are your current ambitions?

Relationships in your family of origin. Please describe the following:

Your parents' relationship with each other:

Your relationship with each parent and with other adults present:

____
____
____
____
____
____

Your parents' physical health problems, chemical use, and mental or emotional difficulties:

____
____
____
____
____
____

Your relationship with your brothers and sisters, in the past and present:

____
____
____
____

Abuse history: ___ I was not abused in any way.
___ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?

Underline any of the following that were applicable to your childhood/adolescence:

Happy childhood	School problems	Medical problems
Unhappy childhood	Family problems	Alcohol abuse
Emotional/Behavior problems	Strong Religious Convictions	Legal Troubles

Present relationships

How do you get along with your present spouse or partner?

___
___
___
___

How do you get along with your children?

___
___
___
___
___

Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

Chemical use

Have you ever felt the need to cut down on your drinking? ___ No ___ Yes

Have you ever felt annoyed by criticism of your drinking? ___ No ___ Yes

Have you ever felt guilty about your drinking? ___ No ___ Yes

Have you ever taken a morning "eye-opener? ___ No ___ Yes

How much beer, wine, or hard liquor do you consume each week, on the average?
____

How much tobacco do you smoke or chew each week? ___________________________

Which drugs (not medications prescribed for you) have you used in the last 10 years?
____
____
____
____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:
____
____
____
____

Legal history

Are you presently suing anyone or thinking of suing anyone? If yes, please explain:
____
____

Is your reason for coming to see me related to an accident or injury? If yes, please explain:
____
____
____

Are you required by a court, the police, or a probation/parole officer to have this appointment? If yes, please explain:
____
____
____
____

If you are involved in legal litigation, please provide your current attorney's information:
Name_________________________________ Phone: _____________________
Address:

Are there any other legal involvements I should know about?_________________
____
____
____
____
____
____

STRENGTHS:

What are some special talents or skills that you feel proud of?
____
____
____

What are some ways that you relax? Play? Spend free time?
____
____
____

CONCERNS THAT YOU WISH TO BE ADDRESSED IN THERAPY:
Please circle all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns circled.

I have no problem or concern bringing me here
Abuse-physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
Aggression, violence
Alcohol use
Anger, hostility, arguing, irritability
Anxiety, nervousness
Attention, concentration, distractibility
Career concerns, goals, and choices
Childhood issues (your own childhood)
Children, child management, child care, parenting
Codependence
Confusion
Compulsions
Custody of children
Decision making, indecision, mixed feelings, putting off decisions

Delusions (false ideas)
Dependence
Depression, low mood, sadness, crying
Divorce, separation
Drug use—prescription medications, over-the-counter medications, street drugs Eating problems—overeating, under-eating, appetite, vomiting (see also "Weight and diet issues")
Emptiness
Failure
Fatigue, tiredness, low energy
Fears, phobias
Financial or money troubles, debt, impulsive spending, low income
Friendships
Gambling
Grieving, mourning, deaths, losses, divorce
Guilt
Headaches, other kinds of pains
Health, illness, medical concerns, physical problems
Inferiority feelings
Interpersonal conflicts
Impulsiveness, loss of control, outbursts
Irresponsibility
Judgment problems, risk taking
Legal matters, charges, suits
Loneliness
Marital conflict, distance/coldness, infidelity/affairs, remarriage
Memory problems
Menstrual problems, PMS, menopause
Mood swings
Motivation, laziness
Nervousness tension
Obsessions, compulsions (thoughts or actions that repeat themselves)
Oversensitivity to rejection
Panic or anxiety attacks
Perfectionism
Pessimism
Procrastination, work inhibitions, laziness Relationship problems
School problems (see also "Career concerns, Self-centeredness)
Self-esteem
Self-neglect, poor self-care
Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
Shyness; oversensitivity to criticism
Sleep problems—too much, too little, insomnia, nightmares
Smoking and tobacco use
Stress relaxation, stress management, stress disorders, tension
Suspiciousness
Suicidal thoughts
Temper problems, self-control, low frustration tolerance

Thought disorganization and confusion
Threats, violence
Weight and diet issues
Withdrawal, isolating
Work problems, employment, workaholism/overworking, can't keep a job
Any other concerns or issues:

Of the concerns marked which would you most like help with? ______________________
____
____

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: ____
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I AUTHORIZE THAT THIS INFORMATION IS ACCURATE AND COMPLETE. I AGREE TO DISCUSS ANY ADDITIONAL AREAS OF CONCERN WITH THE THERAPIST.

Signature___________________________________ Date:__________________________