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Adult Intake Form

NAME: _____
First name Middle Initial Last Name Maiden Name

DOB: _____ **AGE:** _____ **SS NUMBER:** _____ **GENDER:** MALE FEMALE

ADDRESS: _____ **APT.#:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

PHONE NUMBER: _____
Home Cell Work

MARITAL STATUS: SINGLE MARRIED

RACE/ETHNICITY:
 African American/Black Caucasian/White Japanese Hispanic
 Asian Chinese Native American Biracial
 Hawaiian Vietnamese Other

Others residing in the household: _____

Are there any immediate family members in the military? _____ **If so, have they served in combat?** _____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT? _____

IS TREATMENT COURT ORDERED? Yes No

WHO REFERRED YOU TO OUR AGENCY: _____

EMPLOYMENT INFORMATION: Full-time Student Part-time Student Employed N/A

Name of Employer: _____ Job Title: _____

Name of College/University: _____

LIST HOBBIES OR RECREATIONAL INTERESTS: _____

FAMILY, CULTURE AND RELIGION: Describe any cultural and/or religious connections. _____

BEREAVEMENT AND GRIEF: Have you experienced grief or loss? If so, please describe how you are supported socially, spiritually and culturally. _____

PRIMARY CARE PHYSICIAN (PCP):

NAME: _____ **PHONE:** _____

ADDRESS: _____

Visit/Checkup with PCP within the past 12 months: YES NO Regular preventative health screens: YES NO

CURRENTLY PRESCRIBED MEDICATIONS: (Medication, dosage and prescribing physician)

Have you been consistently taking these medications as prescribed YES NO

PATIENT MEDICAL/PSYCHIATRIC HISTORY: (Please check those that apply)

- ASTHMA SEIZURES KIDNEY DISEASE HIGH BLOOD PRESSURE BIPOLAR DISORDER
 CANCER THYROID PROBLEMS LIVER DISEASE ABUSE: PHYSICAL SCHIZOPHRENIA
 DIABETES HEART DISEASE SEIZURES ABUSE: SEXUAL WEIGHT PROBLEM
 SEASONAL ALLERGIES HEAD INJURY/LOSS OF CONSCIOUSNESS OTHER _____

History of hospitalization due to a medical condition: YES NO IF YES, _____

Medication Allergies _____ Food Allergies _____

MENTAL HEALTH HISTORY:

- No previous therapy COMCARE
 Outpatient Treatment

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: _____

Dates of treatment: _____

Reason for treatment: _____

Please document additional treatment episodes on a separate sheet

INPATIENT PSYCHIATRIC HOSPITALIZATION:

Previously hospitalized: Yes No N/A Multiple Hospitalizations: Yes x _____

Last psychiatric facility _____ Date Admitted _____ Date Dismissed _____

Please document additional hospitalizations on a separate sheet

HAVE YOU EVER RECEIVED A MENTAL HEALTH DIAGNOSIS (i.e. depression, bipolar disorder, schizophrenia)

SUBSTANCE USE HISTORY:

NONE

- ALCOHOL WITH BLACK OUTS WITH LEGAL PROBLEMS COURT ORDERED TREATMENT
 OTHER SUBSTANCE USE _____

Have you attended alcohol/drug abuse treatment: Yes No Have you been told that you have an alcohol/drug problem: Yes No

FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for immediate family "2" for extended family)

- Diabetes Depression Anxiety Psychiatric hospitalizations
 Heart Disease Schizophrenia Suicide attempts Alcohol/drugs Other: _____
 ADHD Bipolar disorder Antisocial behavior (difficulties – police/violence) _____

GENERAL FUNCTIONING:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sad or tearful most of the time | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Decrease in interests / activities | <input type="checkbox"/> Extreme ups and downs in mood | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Distinct periods of nonstop activity | <input type="checkbox"/> Decreased appetite |
| <input type="checkbox"/> Down most days | <input type="checkbox"/> Fast/rapid speech | <input type="checkbox"/> Weight loss / gain |
| <input type="checkbox"/> No energy | <input type="checkbox"/> Fearless/engaging in reckless activities | <input type="checkbox"/> Intentional vomiting/purging |
| <input type="checkbox"/> Difficulty thinking | <input type="checkbox"/> Exaggerated view of abilities | <input type="checkbox"/> Binge eating |
| <input type="checkbox"/> Overly fatigued during the day | <input type="checkbox"/> Feel rested after 3-4 hours sleep/night | <input type="checkbox"/> Cheerful/happy most of the time |
| <input type="checkbox"/> Under active/sluggish behavior | <input type="checkbox"/> Inability to sustain attention | <input type="checkbox"/> History of abuse as a child |
| <input type="checkbox"/> Takes more than an hour to fall asleep | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> History of abuse as an adult |
| <input type="checkbox"/> Night waking for longer than 30 minutes | <input type="checkbox"/> Inability to complete tasks | <input type="checkbox"/> Problems with work/school performance |
| <input type="checkbox"/> Sleep too much | <input type="checkbox"/> Restless | <input type="checkbox"/> Problems with relationships at home |
| <input type="checkbox"/> Hard to wake up in the morning | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Extreme conflict with others |
| <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Worries about _____ | <input type="checkbox"/> Threatened to hurt someone w/ intent |
| <input type="checkbox"/> Intentional self harm | <input type="checkbox"/> Fearful of places, situations or people | <input type="checkbox"/> Verbal threats of harm to others |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Physical aggression |
| <input type="checkbox"/> Suicidal attempts | <input type="checkbox"/> Tense | <input type="checkbox"/> Sexual concerns |

HOW LONG HAVE YOU HAD THESE CONCERNS? _____

HOW OFTEN DO THESE OCCUR? _____

WHAT ARE 3 OF YOUR STRENGTHS? _____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOURSELF?

CONSENT AND AUTHORIZATION

By signing below you are:

- Authorizing Youthville Family Consultation Service to provide the client with mental health services.
- Acknowledging that Youthville Family Consultation Service will provide these services in a confidential and professional manner that complies with State and Federal laws and professional standards.
- Acknowledging that you have been informed that services not covered by the insurance company will be the responsibility of the client.
- Acknowledging that you have received a copy of the Client Rights and Responsibilities.
- Acknowledging that you have signed a copy of the Financial Agreement & understand the terms of this agreement.

CONSENT AND AUTHORIZATION: (MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES)

Signature X _____ Date _____

Youthville Family Consultation Service is an equal opportunity employer. Services are provided to people without regard to race, religion, color, sex, ancestry, national origin, handicap, age or political affiliation.