



Adult Intake Form

08/17/10

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 Asian Caucasian/White Chinese Hawaiian Japanese Native American Vietnamese Hispanic Biracial 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: _____

FINANCIAL: Does financial stress relate to why you are seeking services? Yes No

If yes, please explain: _____

LEGAL HISTORY: Have you even been charged with a crime? Yes No Are you currently on probation? Yes No

If yes, please explain: _____

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/HEALTH: (Please check all that apply – past or current)

	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT EAR INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SIGNIFICANT WT. GAIN/LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTRO INTESTINAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Are you currently being seen for any of the above? YES NO IF YES, PLEASE DESCRIBE _____

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

Medication Allergies _____

NUTRITION: (Please check all that apply – past or current)

	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>
INCREASED APPETITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BINGE EATING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DECREASED APPETITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HOARDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Are you currently being seen for any of the above? YES NO IF YES, PLEASE DESCRIBE _____

Food Allergies _____

I have made myself throw-up after eating YES NO I do not eat a wide variety of healthy foods YES NO

PAIN:

	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>
CHRONIC PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, PLEASE DESCRIBE: _____

Are you currently being seen for any of the above? YES NO IF YES, PLEASE DESCRIBE _____

I experience a decrease in my ability to function in life due to this pain YES NO

PSYCHIATRIC HISTORY:

	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ABUSE: SEXUAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ABUSE: PHYSICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EATING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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

GAMBLING HISTORY:

Are you seeking services for a gambling addiction: Yes No

If so, have you ever lied about your gambling: Yes No

If so, have you ever increased bets to get the same sense of action: 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:

Sad or tearful most of the time

Irritability/anger

Poor memory

Decrease in interests / activities

Extreme ups and downs in mood

Increased appetite

Feelings of guilt

Distinct periods of nonstop activity

Decreased appetite

Down most days

Fast/rapid speech

Weight loss / gain

No energy

Fearless/engaging in reckless activities

Intentional vomiting/purging

Difficulty thinking

Exaggerated view of abilities

Overly fatigued during the day

Feel rested after 3-4 hours sleep/night

Cheerful/happy most of the time

Tense

Under active/sluggish behavior

Inability to sustain attention

History of abuse as a child

Takes more than an hour to fall asleep

Difficulty concentrating

History of abuse as an adult

Night waking for longer than 30 minutes

Inability to complete tasks

Problems with work/school performance

Sleep too much

Restless

Problems with relationships at home

Hard to wake up in the morning

Easily distracted

Extreme conflict with others

Feelings of hopelessness

Worries about _____

Threatened to hurt someone w/ intent

Intentional self harm

Fearful of places, situations or people

Verbal threats of harm to others

Suicidal thoughts

Nightmares

Physical aggression

Suicidal attempts

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 to provide the client with mental health services.
- Acknowledging that Youthville 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.

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

Signature X _____ Date _____

Youthville 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.