TalkaWhile
Child and Family Therapy Center PC

ADULT INTAKE FORM

This questionnaire will help us get to know a little more about you and how we may be of help. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet. Please complete this questionnaire as honestly and completely as possible.

All responses you provide will be kept confidential unless you choose to release this information to someone or report that you are seriously harming yourself or someone else, or someone has seriously harmed you.

Name: _____ Date: _____
Date of Birth: _____ Age: _____
Gender Identity: □ Male □ Female □ Transgender □ Other: _____
Race/Ethnicity: _____
Religious Preference/Affiliation: _____
Employer: _____
Occupation: _____
Marital Status: □ Single □ Cohabitating/living together □ Engaged □ Married
□ Separated/Divorced □ Engaged □ Married □ Remarried □ Widowed

Please answer the following (if applicable):
If you have a partner or spouse, how long have you been together? _____
_____

If you are separated or divorced, when did you separate and/or divorce? _____
_____

If you are widowed, in what year did your spouse pass away and how? _____
_____

If you are a parent, please list your child(ren's) name(s), age(s), and the quality of your relationship.

Name	Age	Poor Average Good
		☐ ☐ ☐
		☐ ☐ ☐
		☐ ☐ ☐
		☐ ☐ ☐
		☐ ☐ ☐

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Please list the individuals that currently live in your residence (please include adults, children, and any relevant extended family members or caregivers).

Name	Age	Relationship	Occupation/Grade

CURRENT REASON FOR SEEKING THERAPY:

Briefly describe the main problem(s) or reason(s) for which you are seeking help now.

_____

_____

_____

Whose idea was it for you to reach out to us?

□ Mine □ Spouse/Partner □ Friend □ Parent □ Child □ Other: _____

What do you hope to get from this appointment and what would you like to see happen as a result of therapy/counseling? _____

_____

_____

How important is this change for you? _____

THERAPY/COUNSELING HISTORY:

Have you previously been in therapy or counseling, including individual, group, marital, or family therapy? □ Yes □ No

If yes, with whom did you work, what were the approximate dates of therapy, and the reason(s) you attended therapy?

_____

_____

_____

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If yes, what did you find most helpful in therapy? _____
_____
_____

If yes, what did you find least helpful in therapy and what did not work for you?
_____
_____
_____

Have you ever taken medication for a mental health reason? □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____
_____

SAFETY/RISK CONCERNS:

Have you ever had current or past thoughts or feelings of?

	Never or not at all	In the past	Sometimes	Often	All the time
Hurting or injuring yourself on purpose					
Feeling it is too painful to keep living or that you would be better off dead					
Thoughts of suicide					
Thoughts about specific ways to kill yourself					
Thoughts about hurting or killing others					
Hearing voices or seeing things that are not there					
Feeling like people are out to get you					

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Have you ever purposely harmed yourself (e.g. cut, burned, bruised your body, or other)?
□ Yes □ No
If yes, please provide additional details. _____
_____
_____

Have you ever attempted suicide? □ Yes □ No
If yes, please provide additional details. _____
_____
_____

Have you ever been evaluated for danger to self, danger to others, and/or grave disability (5150 evaluation)? □ Yes □ No □ Unsure
If yes or unsure, please provide additional details (e.g. date(s) of evaluation(s), location, person whom completed evaluation).
_____
_____
_____

Have you ever been psychiatrically hospitalized for danger to self, danger to others, or grave disability (5150 Hold)? □ Yes □ No □ Unsure
If yes or unsure, please provide additional details (e.g. date(s) of hospitalization, reason for hospitalization, inpatient facility where you resided during this stay/multiple stays).
_____
_____
_____

Are there any firearms in your home? □ Yes □ No
If yes, how are they secured? Please explain. _____

Violence in our homes and communities can greatly impact our physical and emotional health. Do you feel safe at home? □ Yes □ No □ Unsure
If no or unsure, please explain. _____
_____
_____

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MEDICAL HISTORY:

Have you ever experienced any serious, chronic, or recurrent health, medical problems, or disabilities in past or present? (Please check all that apply)

- □ Allergies
- □ Asthma
- □ Operations
- □ Head injuries
- □ Poisoning
- □ Serious Infection
- □ Convulsions
- □ Bladder/bowel problems
- □ Ear Infections
- □ Other:

Have you ever been hospitalized for any physical health problems? □ Yes □ No
If yes, please explain. _____
_____

Do you currently take medication(s) for physical health or medical problems? □ Yes □ No
If yes, please describe (e.g. medication name, start date, current dosage/frequency, prescription reason). _____
_____
_____

Do you currently take medication(s) or supplements to treat mental/emotional difficulties or drug or alcohol use? □ Yes □ No
If yes, please provide additional details (e.g. medication name, start date, current dosage/frequency, prescription reason). _____
_____
_____

What is the name of the physician or psychiatrist who is managing your medication(s)?
_____

Physician's/Psychiatrist's address: _____

Health Habits

How often do you exercise per day?
□ 0 □ 30 minutes □ 1-2 hours □ 3 or more hours

How would you describe your current physical health? □ Poor □ Fair/Moderate □ Good

When was your last physical examination by a PCP? _____

How would you describe your current appetite and/or eating habits?
□ Poor □ Fair/Moderate □ Good

How would you describe your current sleeping habits?
□ Poor □ Fair/Moderate □ Good

How many hours do you sleep at night?
□ 5 hours or less □ 6-7 hours □ 8-10 hours □ 11-12 hours

Do you have any sleep problems/disturbances? □ Yes □ No
If yes, please explain. _____
_____

SUBSTANCE USE HISTORY:

Please describe your current substance use.

	Never	Daily	Weekly	Occasionally	Rarely	Past Use Only
Alcohol						
Tobacco						
Marijuana						
Other Drugs						

If you endorsed any substance use (please answer the following questions below):
Please provide additional details (e.g. type of substance, frequency, amount, setting – alone, socially, first use, last use).

_____
_____
_____
_____

Have you ever passed out, blacked out, or had the “shakes”?
□ Yes □ No

Have have you ever drank or used substances in the morning to steady your nerves or relieve a hangover? □ Yes □ No

Have you ever used more than 1 substance at the same time to get high? □ Yes □ No

Do you avoid family activities so you can use? □ Yes □ No

Do you have a group of friends whom also use? □ Yes □ No

Have you ever felt you should cut down on your use? □ Yes □ No

Have you ever felt bad or guilty about your use? □ Yes □ No

Have you received any previous treatment for chemical/substance use? □ Yes □ No
If yes, please explain where you went and what type of treatment you received.

_____

_____

Have you ever been hospitalized in an inpatient or rehab facility for drug or alcohol use?
□ Yes □ No □ Unsure
If yes or unsure, please provide additional details (e.g. date(s) of hospitalization, reason for hospitalization, inpatient facility or rehab facility where you resided during this stay/multiple stays).

_____

_____

_____

FAMILY BACKROUND/HISTORY:

Where were you born? _____

Where did you grow up? _____

_____

What is your mother's name? _____Is she your biological parent? □ Yes □ No

If applicable, is your mother alive or deceased? _____

If alive, what is her age and health status? _____

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If deceased, in what year did she pass away and what was the cause of her death?

_____

What is your father's name? _____ Is he your biological parent? □ Yes □ No

If applicable, is your father alive or deceased? _____

If alive, what is his age and health status? _____

If deceased, in what year did he pass away and was the cause of his death?

_____

Were your parents married? □ Yes □ No □ Unsure

If your parents were married, did they separate or divorce? □ Yes □ No □ Unsure
If yes, in what year did they divorce and why? _____

_____

_____

With whom did you primarily live while growing up?
□ Both parents □ Mother □ Father □ Other: _____

Please describe the relationship with your siblings(s) (if applicable). Please indicate their name(s), age(s), and the quality of your relationship.

Name	Age	Poor Average Good
		□ □ □
		□ □ □
		□ □ □
		□ □ □
		□ □ □

Early Life Stressors

Before the age of 18, did you experience any of the following:
A chaotic home environment (e.g. frequent fighting, minimal structure, etc.)
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____

_____

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Emotional reactions from your parent(s)/primary caregiver(s) that did not match the severity of what happened (e.g. extreme anger for a small mistake or minimal reaction to an abusive or harsh situation). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Psychological abuse (e.g. were yelled at, falsely punished, subordinated to your siblings, or black mailed). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Sexual abuse (e.g. inappropriately touched, molested, assaulted). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Neglect (e.g. left unattended for extended periods of time, lacked clothing, food, were left soiled/dirty, failed to obtain needed medical/dental care or treatment).
□ Yes □ No □ Unsure.
If yes or unsure, please explain. _____
_____

Bullying, social ostracizing, or difficulty making friends. □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Academic struggles, were disciplined, or reprimanded by teachers, including being sent home, or suspended from school. □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Missed a lot of school. □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Family financial hardship, strain, or instability. □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

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Please provide other details about your childhood or adolescence you'd like to share with us:

_____

_____

FAMILY PSYCHIATRIC HISTORY:

Do you or any of your biological family members have any history of psychiatric, emotional, and/or substance use problems? (Please specify which family members and indicate if family members have experienced these conditions in past or present).

		Relationship to You
Developmental delays or Autism Spectrum Disorders	☐	
Child inattention, hyperactivity, or poor impulse control	☐	
Learning Disabilities	☐	
Depression (2 weeks or more)	☐	
Anxiety, Phobias, Panic Attacks, or OCD	☐	
Mood swings or Bipolar Disorder	☐	
Eating Disorders/Disordered Eating Practices	☐	
Suicide attempts or completion	☐	
Tics/Tourette's Disorder	☐	
Schizophrenia or psychosis	☐	
Alcohol or Drug Use/Abuse	☐	
Antisocial behavior (assaults to family and others, thefts, arrests)	☐	

EMPLOYMENT AND EDUCATION HISTORY:

Are you currently employed? □ Yes □ No
If yes, do you enjoy your work? Is there anything stressful about your current work?

_____

_____

If not currently employed, what was the last occupation/job you held and what were the dates of this employment? _____

_____

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If not currently employed, are you receiving, or have you applied for medical leave or disability benefits? □ Yes □ No □ N/A

Have you ever received medical or disability benefits? □ Yes □ No
If yes, please explain. _____
_____

Are you currently attending school? □ Yes □ No
If yes, where are you going to school and what is your status (e.g. part-time or full-time)?
_____
_____

Please indicate the highest level of education you've completed to date:
□ Elementary School □ Middle School □ Some High School
□ High School Diploma/GED □ Some college □ Associate's Degree: Academic program
□ Associate's Degree: Occupational, technical, or vocational program □ Bachelor's Degree
□ Graduate degree or higher

Did you ever receive any special education services while a student (e.g. academic tutoring, 504 plan/classroom accommodations, or IEP)? □ Yes □ No
If yes, please explain. _____
_____

SOCIAL SUPPORT SYSTEMS:

How many good friends do you have that you can depend on if you needed them?
□ 0 □ 1 □ 2-3 □ 4 or more

How do you feel about your friendships?
□ Unsatisfied □ Neutral/Okay □ Satisfied

Do you have any hobbies or participate in any social activities? □ Yes □ No
If yes, please describe. _____
_____

OTHER INFORMATION:

Tell us a little about yourself. _____
_____
_____

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Describe your strengths and unique qualities. _____
_____
_____

Have you ever been arrested, cited, or detained by any law enforcement officer for any reason? □ Yes □ No
If yes, please explain. _____
_____

Have you experienced any sources of stress within the last year? □ Yes □ No
If yes, please explain. _____
_____

Is there any other information you would like us to know? _____
_____
_____