ADDITIONAL INTAKE INFORMATION

Name	Today's date

Please briefly describe your reason(s) for seeking help.

MENTAL HEALTH TREATMENT AND FAMILY HISTORY

Outpatient treatment?	☐ Yes	☐ No	Inpatient treatment?	☐ Yes	☐ No
If yes, did it help?	☐ Yes	☐ No	Where		
Therapist's name			Dates of treatment		
Dates of treatment					

Family history of mental/emotional/behavioral problems?	☐ Yes	☐ No
If yes, who?		
Relationship to you:		

MEDICAL HEALTH STATUS AND HISTORY

List any medical or physical problems and when they were diagnosed.

List any major (where you were put to sleep) surgeries you have had to date.

List any serious illness or injuries you have had, especially anything involving your head.

List any food or drug allergies you have.

Date of your last physical examination:			Name of your physician:
May we contact your physician?	☐ Yes	☐ No	Physician's contact information (address and phone)
See "Privacy Practices" statement for more information on releases of your information.			

CURRENT ISSUES

Please check any of the following that apply to you.

☐ Thoughts of suicide	☐ Thoughts of harming others	☐ Phobias
☐ Trouble getting to sleep	☐ History of suicide attempts	☐ Panic attacks
☐ Waking during the night	☐ Cutting or hurting yourself	☐ Excessive guilt
☐ Waking early almost every day	☐ Feeling hopeless	☐ Forgetfulness
☐ Financial problems	☐ Unable to make decisions	☐ Mood swings
☐ Loss of appetite	☐ Trouble controlling your temper	☐ Health problems
☐ Hearing non-existent voices	☐ Large unexpected weight gain or loss	☐ Family problems
☐ Problems at work	☐ Seeing things others don't	☐ Violence toward others
☐ Trouble concentrating	☐ Past or current physical abuse	☐ Tingling or numbness
☐ Racing thoughts	☐ Past or current sexual abuse or assault	☐ Depressed mood
☐ Legal problems	☐ Past or current emotional abuse	☐ Missing hours or days

PLEASE CONTINUE TO SECOND PAGE

SUBSTANCE USE

Please list all of the prescription and over-the-counter drugs you are taking and their dosages.

Please complete this chart based on the substances you use in any amount at all.

	Age of first use	Frequency/Quantities (How much and how often?)			
		Weekday	Weekend	Month	Last use date
Beer					
Spirits/Liquor					
Wine					
Marijuana					
Cocaine/Crack					
Methamphetamine/Crystal Meth					
Heroin					
Barbiturates (Downers)					
PCP, LSD (Hallucinogens)					
Tobacco (in any form)					
Other (please list)					

Adults (18 years of age and older) please answer the following questions.

Question		
Have you ever felt like you should cut down on our drug or alcohol use?	□ Yes	□ No
Has a friend or relative expressed concerns about your use?	□ Yes	□ No
Have you ever felt guilty about your drinking or drug use?	□ Yes	□ No
Have you ever had to take a drink or use a drug the next day to steady your nerves?	□ Yes	□ No
Are you a recovering alcoholic or a recovering drug addict?	□ Yes	□ No
Is there a history or problems with drug or alcohol use in your family?	□ Yes	□ No

Adolescents (12 years to 17 years of age) please answer the following questions.

Question		
Have you ever used alcohol or drugs before or during school?	□ Yes	□ No
Have you ever missed school (or been truant) because of use or just to use?	□ Yes	□ No
Have you ever avoided non-users?	□ Yes	□ No
How often do you get drunk or high?		
About how often do you use more than one drug when you get high?		
Is there a history or problems with drug or alcohol use in your family?	□ Yes	□ No

SIGNATURES

Client signature	Date	Clinician signature	Date