AccessLiving
Counseling and Developmental Services

Intake Form

Name of person completing this section (if different than patient) and relationship to patient:

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

What [problems are you having which prompted you to come to this clinic?

What are your goals/expectations for treatment?

Please review the following and check any current symptoms that pertain to you.

- ☐ Lost or gained weight without meaning to. How much? _____ What time frame? _____
- ☐ Sleep too much/not enough
  - How many hours? _____ Snore? _____ Trouble going to sleep? _____
  - Waking at night or early morning? _____ If so can you go back to sleep? _____
- ☐ Thoughts of death or suicide?
  - How often? _____ Plans? _____ Previous attempts? _____
  - How many? _____ When was your last attempt? _____

☐ Depressed Mood	☐ Recurrent nightmares
☐ Stopped enjoying usual activities	☐ Want to avoid thoughts, feelings and conversations about trauma
☐ Agitated	☐ Difficulty concentrating
☐ No energy/always tired	☐ Exaggerated startle response
☐ Feel guilty/worthless	☐ Always on guard/never feel safe
☐ Can't think or concentrate	☐ Panic attacks
☐ Inflated self-esteem	☐ Afraid/unable to leave home
☐ Don't seem to need sleep	☐ Extreme unreasonable fears
☐ Excessive talking	☐ Intense fear of social situations
☐ Racing thoughts	☐ Can't prevent repetitive thoughts
☐ Highly distractible	☐ Can't prevent repetitive behaviors
☐ Try to do way too much	☐ Extreme fears of abandonment
☐ Impulsive Behavior	☐ Pattern of intense relationships
☐ See or hear things that may not be real	☐ Poor self-image
☐ Suspect or believe things that may not be real	☐ Impulsivity
☐ Often tense/unable to relax	☐ Self-harming behaviors
☐ Excessive worry	☐ Intense rapid mood changes
☐ Feeling easily fatigued	☐ Chronic feelings of emptiness
☐ Irritability	☐ Inability to control anger
☐ Muscle tension	☐ Feelings of paranoia that come and go
☐ Recurrent and intrusive recollections of a trauma	☐ Acting or feeling as if the traumatic events are recurring

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Have you ever been hospitalized for psychiatric reasons? _____ YES _____ NO

If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist? _____ YES _____ NO

If yes, when and where?

Have you ever received counseling or psychotherapy in the past? _____ YES _____ NO

If yes, when and where?

FAMILY HISTORY

Consider your biological immediate family and all relatives on both sides of your family (parents, brothers, sisters, aunts, uncles and grandparents). Review the list below- if any relative has one of these disorders, check the disorder and describe their relation to you (such as "maternal uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is the father's side of the family.

Depression _____
Anxiety _____
ADHD _____
Bipolar (manic depressive) _____
Schizophrenia _____
Alcohol/Drug Problems _____
Learning Disabilities _____
Autism/Asperger/Pervasive Developmental Disorder _____
Mental Retardation _____
"Nervous Breakdown" _____
Psyhiatric Hospitalization _____
Suicide or Attempts _____
Panic Disorder _____
PTSD (Post Traumatic Stress Disorder) _____
OCD (Obsessive Compulsive Disorder) _____
Heart Disease or arrhythmias _____
Thyroid _____
Immunological disorders (lupus, scleroderma, inflammatory, bowel disease) _____
Diabetes _____

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GENERAL MEDICAL HISTORY

Do you have a Primary Care Physician? _____ YES _____ NO
Name:

Date of Last Physical Exam: Date of Last Laboratory Work:

Do you suffer from any of the following general medical problems?

☐ Chest Pain	☐ Motor Difficulties	☐ Memory Problems	☐ Sinus or Nasal Problems
☐ Heart Attack	☐ Serious Head Injury	☐ Early Fatigue	☐ Muscle Cramps
☐ Coronary Artery Disease	☐ Recurring Headaches	☐ Daytime Sleepiness	☐ Muscle Stiffness
☐ Rheumatic Fever	☐ Kidney Disease	☐ Concentration Problems	☐ Weakness
☐ High/Low Blood Pressure	☐ Sexually Transmitted Disease	☐ Depressed Immune System	☐ Tremors
☐ Stroke	☐ Diabetes	☐ Cancer	☐ Recurrent Infection of any kind
☐ Heart Palpations	☐ Thyroid Disease	☐ Lung Disease	☐ Numbness
☐ Pace Maker Implant	☐ Hormone Problems	☐ Asthma	☐ Difficulty Walking
☐ Heart Surgery	☐ Fever or Sweats	☐ Emphysema	☐ Uncontrolled Movement
☐ Neurological Disorders	☐ Blood Disease	☐ Chronic Cough	☐ Liver Disease
☐ Seizures	☐ Anemia	☐ Bronchitis	☐ Jaundice
☐ Epilepsy	☐ Bruise Easily	☐ Pneumonia	☐ Hepatitis
☐ Fainting	☐ Nose Bleed	☐ Tuberculosis	☐ Stomach Ulcers
☐ Vertigo/Dizziness	☐ HIV	☐ Shortness of Breath	☐ Nausea/Vomiting
☐ Skin rash	☐ Visual Spots	☐ Arthritis	☐ Unusual Diet
☐ Skin Ulcer/Lesion	☐ Double Vision	☐ Speaking Problems	☐ Abdominal Pain
☐ Recent Trauma	☐ Glaucoma	☐ Hearing Problems	☐ Other

Have you undergone any surgical procedure? _____ YES _____ NO
Please list the surgical procedure with the date(s) of surgery:

Do you have problems with chronic physical pain? _____ YES _____ NO

Rate average pain level: Circle one 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst)

Have you ever suffered a severe head injury with loss of consciousness or concussion?
_____ YES _____ NO

Have you fallen in the past year? _____ YES _____ NO

SOCIAL HISTORY

Do you live alone? _____ YES _____ NO List who lives with you:

Are you married or in a relationship currently? _____ YES _____ NO

Name of significant other:

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Significant others employment:

Relationship with current significant other:

How many previous marriages or long term relationships?

Children? _____ YES _____ NO (List)

Name: Age: Relationship: Living with you?

Do you have any pets? _____ YES _____ NO

Where did you grow up?

Did you parents stay together while you were growing up? _____ YES _____ NO

If parents separated, how old were you and who did you live with?

Father's occupation:

Mother's occupation:

How many siblings do you have? _____None _____Brothers _____Sisters

Do you exercise? _____ YES _____ NO

Do you need daily help to care for yourself? (ex. Bathing, cooking, and other household duties) If yes please explain

_____ YES _____ NO

What are some of the things you enjoy doing? (Hobbies, sports, past time, etc.)

Have you been convicted of any crimes, incarcerated in prison, parole or probation? _____ YES _____ NO

TRAUMA HISTORY _____ YES _____ NO

If yes, what was the nature of the trauma? (Please circle all that apply)

Physical	Emotional	Neglect
Accidents	Disasters	Sexual
Witnessing Violence	War	Other:

EDUCATON/LEARNING

Did you graduate from high school? _____ YES _____ NO Last grade attended: _____

If not why did you stop going to high school? _____

_____

Any college or further training? _____ YES _____ NO

What type of jobs have you had in the past?

Have you had trouble keeping jobs? _____ YES _____ NO

How do you learn best? _____Verbal explanation _____Written handouts _____Other:

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Do you have any physical limitations that make learning difficult for you? _____ YES _____ NO
If yes, explain? (such as trouble seeing/hearing, difficulty reading, speaking a different language)

Are you currently employed? _____ YES _____ NO
If yes, where and how long?

Are you receiving or applying for: ____SSD _____SSI _____Medicaid

ALCOHOL, DRUG, AND TOBACCO USE ☐ check if none

Alcohol Current use/date of last use:

Past use:

Problems related to use? _____ YES _____ NO (legal, financial, health, relationship) List:

Treatment required? _____ YES _____ NO (Describe)

ILLICIT DRUG AND/OR PRESCRIPTION DRUG ABUSE

Substance	Date of Last Use	Problems Related to use		Treatment Required	
Benzodiazepines (Valium, Xanax, Ativan)		YES	NO	YES	NO
Caffeine		YES	NO	YES	NO
Marijuana		YES	NO	YES	NO
Cocaine		YES	NO	YES	NO
Designer Drugs (Club Drugs: G, X)		YES	NO	YES	NO
Hallucinogens (LSD, Mushrooms)		YES	NO	YES	NO
Inhalants (Gasoline, Glue, Aerosol)		YES	NO	YES	NO
Methamphetamines (Speed, Ice, Ritalin)		YES	NO	YES	NO
Opiates/Methadone (vicodin, Oxycontin, Heroin)		YES	NO	YES	NO
OTHER		YES	NO	YES	NO

Tobacco _____NONE Amount per day:

SOCIAL SUPPORTS

Is there anyone you trust or confide in during times of trouble? _____ YES _____ NO
(Name Supports)

Do you have any religious ties or involvement in a church? _____ YES _____ NO (Describe)

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MEDICATIONS

Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you had from them? See list:

Adderall ® (dextroamphetamine + amphetamine)	Ginseng	ReVia ® (naltrexone)
Abilify ® (aripiprazole)	Halcion ® (triazolam)	Rexulti (brexpiprazole)
Adipex-P ® (phentermine)	Haldol ® (haloperidol)	Risperdal ® (risperidone)
Ambien ® (zolpidem)	imipramine (Tofranil ®)	Ritalin ® (methylphenidate)
Amoxapine	Inderal ® (propranolol)	SAM-e
Antabuse ® (disulfiram)	Keppra ® (levetiracetam)	Saint john's wort Saphris (asenapine)
Anafranil ® (clomipramine)	Klonopin ® (clonazepam)	Sarafem ® (fluoxetine)
Aricept ® (donepezil)	Lamictal ® (lamotrigine)	Serax ® (oxazepam)
Ativan ® (lorazepam)	Latuda (lurasidone)	Seroquel ® (quetiapine)
Aventyl ® (nortriptyline)	Lexapro ® (escitalopram)	Serzone ® (nefazodone)
Benadryl ® (diphenhydramine)	Librium ® (chlordiazepoxide)	Sinequan ® (doxepin)
Brintellix (vortioxetine)	Lithobid ® (lithium)	Sonata ® (zaleplon)
Buspar ® (buspirone)	Loxitane ® (loxapine)	Stelazine ® (trifluoperazine)
Carbatrol ® (carbamazepine)	Luminal ® (phenobarbital)	Strattera ® (atomoxetine)
Catapres ® (clonidine)	Luvox ® (fluvoxamine)	Subutex ® (buprenorphine)
Celexa ® (citalopram)	Melatonin	Suboxone ® (buprenorphine + naloxone)
Chloral hydrate Clozaril ® (clozapine)	Mellaril ® (thioridazine)	Symbiax ® (olanzapine + fluoxetine)
Cogentin ® (benztropine)	Marplan ® (isocarboxazid)	Tegretol ® (carbamazepine)
Concerta ® (methylphenidate)	Meridia ® (sibutramine)	Tenex ® (guanfacine)
Cymbalta ® (duloxetine)	Metadate ® (methylphenidate)	Tenuate ® (diethylpropion)
Cylert ® (pemoline)	Methylin ® (methylphenidate)	Thorazine ® (chlorpromazine)
Dalmane ® (flurazepam)	Moban ® (molindone)	Tofranil ® (imipramine)
Depakote ® /Depakene ® (valproic acid/ valproate)	Mysoline ® (primidone)	Topamax ® (topiramate)
Dexedrine ® (dextroamphetamine)	Nardil ® (phenelzine)	Tranxene ® (clorazepate)
Didrex ® (benzphetamine)	Navane ® (thiothixene)	trazodone (Desyrel ®)
Dilantin ® (phenytoin)	Neurontin ® (gabapentin)	Trilafon ® (perphenazine)
Dolophine ®	Norpramin ® (desipramine)	Trileptal ® (oxcarbazepine)
Methadose ® (methadone)	ortriptyline (Pamelor ®)	Valerian Valium ® (diazepam)
Effexor XR ® (venlafaxine)	Omega fatty acids Orap ® (pimozide)	Vistaril ® (hydroxyzine)
Elavil ® (amitriptyline)	Pamelor ® (nortriptyline)	Viibryd (vilazodone)
Ephedra ®	Parnate ® (tranylcypromine)	Vyvanse (lisdexamfetamine)
Eskalith ® (lithium)	Paxil ® (paroxetine)	Wellbutrin ® (bupropion)
Evening primrose oil	Periactin ® (cyproheptadine)	Xanax ® (alprazolam)
Fanapt (iloperidone)	Prolixin ® (fluphenazine)	Zarontin ® (ethosuximide)
Fetzima (leromilnacipran)	Propranolol (Inderal ®)	Zoloft ® (sertraline)
Focalin ® (dexmethylphenidate)	ProSom ® (estazolam)	Zonegran ® (zonisamide)
Gabitril ® (tiagabine)	protriptyline (Vivactil ®)	Zyprexa ® (olanzapine)
Geodon ® (ziprasidone)	Provigil ® (modafinil)	Zydis ® (olanzapine)
Ginkgo biloba	Prozac ® (fluoxetine)	
	Remeron ® (mirtazapine)-	
	Restoril ® (temazepam)	

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Are you allergic to any medications? _____YES _____NO If yes, explain below:
Name of Medication: Reaction:

List all your prescription medications including dose and time
(To insure accuracy, please take information directly from your prescription bottles/containers)

Medication	Dose	Route	How Often?	What Time?	Prescriber

Do you take any over the counter medications or herbal supplements? _____YES _____NO (List)

Medication	Dose	Route	How Often?	What Time?

Any other information that you feel needs mentioned?

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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