



ADULT INDIVIDUAL INTAKE INFORMATION

Family information

Patient

Name _____

Birth date _____ Age _____ Social security # _____ - _____ - _____

Address _____

City _____ State _____ Zip code _____

Home phone _____ - _____ - _____ Preferred gender pronoun (e.g., he/she/they) _____

Occupation _____ Work phone _____ - _____ - _____

Employer _____

Address _____

City _____ State _____ Zip code _____

Spouse

Spouse name _____

Birth date _____ Age _____ Social security # _____ - _____ - _____

Address _____

City _____ State _____ Zip code _____

Home phone _____ - _____ - _____ Preferred gender pronoun (e.g., he/she/they) _____

Occupation _____ Work phone _____ - _____ - _____

Employer _____



ADULT INDIVIDUAL INTAKE INFORMATION

Address _____

City _____ State _____ Zip code _____

Children

Child 1 name _____

Living at home? Yes No Birth date _____ Gender pronoun _____

Child 2 name _____

Living at home? Yes No Birth date _____ Gender pronoun _____

Child 3 name _____

Living at home? Yes No Birth date _____ Gender pronoun _____

Other members of household (names, relationships)

Medical and mental health history

Have you ever been diagnosed with the following problems, if so, please indicate year.

AIDS _____

Cancer _____

Arthritis _____

Jaundice _____

Asthma _____

Epilepsy _____

Bronchitis _____

Heart disease _____

Diabetes _____

Hepatitis _____

Dental problems _____

High blood pressure _____

Emphysema _____

HIV positive _____



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Kidney disease _____

Stroke _____

Neurological disease _____

Thyroid _____

Rheumatic fever _____

Tuberculosis _____

Scarlet fever _____

Sexually transmitted infection _____

Sinusitis _____

Head injury _____

Other _____

In the past, have you ever sought treatment for psychological concerns? Yes No

If yes, in how many treatment programs have you participated? _____

If yes, please list where you have been seen for psychological services _____

If yes, please indicate which psychological concern(s) led you to seek treatment in the past. Check as many as apply.

Depression

Sleep problems

Agoraphobia

Bipolar disorder

Post-traumatic stress

Schizophrenia

Panic disorder

Anger control problems

Generalized anxiety

Sexual problems

Obsessive/compulsive disorder

Other (please specify)

Phobias other than agoraphobia

Marital problems

Family problems

Alcohol/drug or gambling problems



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Please check any psychological problems that apply to you that you **have not** sought treatment for. Check as many as apply.

- | | |
|--------------------------------|-----------------------------------|
| Depression | Alcohol/drug or gambling problems |
| Agoraphobia | Sleep problems |
| Post-traumatic stress | Bipolar disorder |
| Panic disorder | Schizophrenia |
| Generalized anxiety | Anger control problems |
| Obsessive/compulsive disorder | Sexual problems |
| Phobias other than agoraphobia | Other (please specify) |
| Marital problems | _____ |
| Family problems | _____ |

To the best of your knowledge, please indicate conditions below that your first-degree relatives (mother, father, siblings) have experienced.

- | | |
|--------------------------------|-----------------------------------|
| Depression | Alcohol/drug or gambling problems |
| Agoraphobia | Sleep problems |
| Post-traumatic stress | Bipolar disorder |
| Panic disorder | Schizophrenia |
| Generalized anxiety | Anger control problems |
| Obsessive/compulsive disorder | Sexual problems |
| Phobias other than agoraphobia | Other (please specify) |
| Marital problems | _____ |
| Family problems | _____ |

Please provide a brief description of problem(s) that led you to seek treatment at this time.



ADULT INDIVIDUAL INTAKE INFORMATION

What are your strengths? _____

Are you currently taking any medications? Yes No

If yes, please list the medication(s) that you are taking: _____

Alcohol/drug use history

How often do you have a drink containing alcohol?

- | | |
|-----------------------------|-----------------------------|
| Never | Two to three times per week |
| Monthly or less | Four to five times per week |
| Two to four times per month | Daily or almost daily |

How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2 3 or 4 5 or 6 7-9 10 or more

How often do you use drugs that are not prescribed (or a greater amount of a drug that is prescribed)?

- Never Monthly or less Two to four times per month
- Two to three times per week Four to five times per week Daily or almost daily



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Please indicate drugs that you currently use.

Cocaine or crack

Marijuana

Hallucinogens (e.g., LD, MOMA)

Uppers (e.g., speed, ice)

Heroin

Methadone

Pain killers

Sedatives or anti-anxiety drugs

Inhalants

PCP, angel dust ketaloar

Other

Have you ever had a drug or alcohol problem and currently abstain? Yes No

Have you ever felt the need to cut down on your drinking or drug use? Yes No

Have you ever been annoyed at criticism of your drinking or drug use? Yes No

Have you ever felt guilty about something you've done when you were drinking or high on drugs? Yes No

Have you ever had a morning eye-opener to control the shakes? Yes No

Demographic information

Marital status

Single Married Living with partner Divorced Separated

Other _____

Number of marriages

One Two Three Four None



ADULT INDIVIDUAL INTAKE INFORMATION

Gender identity (e.g., woman, trans, non-conforming, man) _____

Sexual orientation (e.g., gay, bisexual, heterosexual, questioning) _____

Education

Grade school Some high school GED High school degrees

Some college College degree Post-graduate work Other _____

Race

Asian/Pacific Islander African-American Hispanic/Latino White/Caucasian

Native American Middle Eastern Other _____

Number of job changes (in the last five years)

One Two Three Four Five Six Seven or more None

Number of city to city moves (in the last three years)

One Two Three Four Five Six Seven or more None

Type of residence

Home Apartment Duplex Rooming house Hotel/motel Other _____

Period of residence in Michigan

Six months or less One year Two years Three years Five years

Six years Seven years Eight years or more

Who referred you?

Self Relative/friend Physician School Psychiatric agency

Social agency Non-medical professional Police or court Other _____



ADULT INDIVIDUAL INTAKE INFORMATION

Have you ever been hospitalized for psychiatric reasons?

Once Twice Three times Four times Never

Have you ever attempted suicide? Yes No

Occupation

Unemployed Medical disability Student Sales/service Blue collar

White collar Professional Homemaker Other _____

Gross income

Less than \$10,000 \$10,000-\$20,000 \$20,000-\$30,000 \$50,000-\$60,000

\$60,000-\$70,000 Over \$70,000

Emergency information

Whom to call in case of emergency _____

Address _____

City _____ State _____ Zip code _____

Phone _____ - _____ - _____