Lifelong Wellness

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Confidential ADULT INTAKE FORM

Please print out documents, complete them and bring to our first session
OR arrive 30 minutes prior to scheduled session to complete the forms I will print out for you.
Thank you!

1. **YOUR NAME** _____ DATE OF BIRTH_____/____/_____
(First) (Middle Initial) (Last)
Gender: □ M □ F Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed

Client's **INSURANCE:** _____ Authorization #_____
Client's Member #_____ Co-pay $_____.___

ADDRESS: Number_____ Street _____ Apt _____
City:_____ ZIP _____

PHONES: **Home** ( ) _____ -_____ **Cell** ( ) _____ - _____**Work**( ) _____ - _____
Indicate which Phone to call: ___Home ___Cell __ Work
May I leave a short message related to scheduling? □ Yes □ No

EMAIL: _____ **May I email you?*** □ Yes □ No
* Please note that Email correspondence is not considered a confidential medium of communication.

2. **OTHERS WHO MAY PARTICIPATE IN THERAPY**

NAME _____ DATE OF BIRTH_____/____/_____
(First) (Middle Initial) (Last)
Gender: □ M □ F Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed
ADDRESS: Number_____ Street _____ Apt _____
City:_____ ZIP _____
PHONES: **Home** ( ) _____ -_____ **Cell** ( ) _____ - _____**Work**( ) _____ - _____

NAME _____ DATE OF BIRTH_____/____/_____
(First) (Middle Initial) (Last)
Gender: □ M □ F Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed
ADDRESS: Number_____ Street _____ Apt _____
City:_____ ZIP _____
PHONES: **Home** ( ) _____ -_____**Cell** ( ) _____ - _____**Work**( ) _____ - _____

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3. **FAMILY/HOUSEHOLD MEMBERS.**

Name _____Date of Birth __/____/___ Gender: □ M □ F Relationship:_____

Name _____Date of Birth __/____/___ Gender: □ M □ F Relationship:_____

Name _____Date of Birth __/____/___ Gender: □ M □ F Relationship:_____

Name _____Date of Birth __/____/___ Gender: □ M □ F Relationship:_____

4. For child/teen therapy, co-parenting or mediation – if the co-parent sharing legal custody does not live with you:

CO-PARENT'S NAME:_____ Date of Birth ___/___/_____ □ M □ F
ADDRESS: Number_____ Street _____ Apt _____
City:_____ ZIP _____

PHONES: **Home** ( ) _____ -_____**Cell** ( ) _____ - _____**Work**( ) _____ - _____

5. **STRESSES/CHALLENGES:** What are a few reasons you OR your family member seeks therapy at this time?

_____

_____

_____

_____

_____

_____

_____

_____

6. **GOALS**: What would you like to accomplish during your time in therapy?

_____

_____

_____

_____

_____

7. **PREVIOUS BEHAVIORAL HEALTH SERVICES**
Name(s) of previous therapist/(s): _____ Years of Services ____to _____

What was helpful about working with the therapist(s)? _____

_____

What was not helpful in working with the therapist(s)?_____

_____

8**. CHANGES/ STRESSORS**: What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

9. **STRENGTHS:** What do you consider to be some of your strengths?

_____

_____

_____

_____

10. **SUPPORT SYSTEMS:** What family, friendships, and/or activities do you find helpful in times of need?

_____

_____

11. **AFFILIATIONS:** Do you have a spiritual or religious practice or affiliation? □ No □Yes (please describe):

_____

12. **THOUGHTS, ACTIONS, FEELINGS:** Describe what thoughts, actions feelings may be troubling you.

_____

_____

_____

_____

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13. **FINANCIAL/ HOUSING CONCERNS**: Please describe:

_____

_____

Is the client currently employed? □ Yes □ No

YOUR Employer: _____ Hours/week _____

Role: _____

Do you enjoy your work? □ No □ Somewhat □ Usually □ Most of the time

What is most stressful about your current work? _____

Adult # 2 Employer: _____ Hours/week _____

Role: _____

Does he/she enjoy their work? □ No □ Somewhat □ Usually □ Most of the time

What is most stressful about their current work? _____

PHYSICAL HEALTH INFORMATION

1. Please rate your current physical health? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
   Please list <u>any</u> specific health problems you are currently experiencing including allergies:

   _____

2. When was your last physical examination with your health care provider? Month_____ Year_____

3. Name of Primary Care Provider: _____
   Hospital/HMO:_____

4. Are you currently experiencing any chronic pain? □ Yes □ No
   If yes, please describe _____

5. How well are you sleeping? Average hours of sleep per night _____
   □ Rarely Sleep □ Hard going to sleep □ Wake up / can't get back to sleep □ Nightmares

6. Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

7. Are you currently experiencing overwhelming sadness, grief or depression? □ Yes □ No

   If yes, for how long? _____ Are you having thoughts about ending your life? □ Yes □ No

8. Are you currently experiencing anxiety, PTSD, panic attacks or phobias? □ Yes □ No
   If yes, describe/explain your physical experience:_____

   _____

   _____

   When did you begin experiencing this? _____

   _____

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9. What number of times per week do you exercise (including yoga)? □ none □2 days □ 3 days □ other _____
   What types of exercise do you participate in? _____
   _____

10. What supplements (vitamins, minerals, herbs, tinctures) do you take? _____
    _____

11. Have you ever been prescribed psychiatric medication? □ Yes □ No
    Please list psychiatric medications,, dosage, approximate dates taken, and check the box if they were helpful.
    _____ dosage_____ dates_ _____ to _____ □ Yes □ No
    _____ dosage_____ dates_ _____ to _____ □ Yes □ No
    _____ dosage_____ dates_ _____ to _____ □ Yes □ No

12. Have you ever been hospitalized due to a mental health concern? □ Yes □ No
    Condition:_____ Dates: _____to _____
    Describe:_____

13. SUBSTANCE USE:
    How frequently do you drink alcohol? □ In recovery for ____ years □ Never □ Daily □ Weekly
    How many glasses of alcohol do you drink in one period of time? □ one □ two □ three □_____
    Has your drinking led to difficult consequences? □ Blackouts □DUI □ Work disruption □ Fights

    Do you smoke or inhale marijuana products? □ Yes □ No
    How frequently? Daily: □ one □ two □ three times or Weekly □ one □ two □ three times

    Has your drinking led to difficult consequences? □ Blackouts □DUI □ Work disruption □ Fights

    Have friends/family ever expressed concern for your alcohol or other drug use? □ Yes □ No

14. Do you use drugs not prescribed for you? □ Yes □ No
    If "Yes" how often? □ Infrequently □ Daily □ Weekly □ other _____
    Please list drugs: _____

15. Other health information:
    Significant injuries, illnesses, hospitalizations: _____
    _____

    Chronic conditions:_____
    _____

    FOR WOMEN: # __ pregnancies__ miscarriages __ terminations of pregnancy ___ births
    difficult menstrual cycles _____
    difficult pregnancies_____
    difficult births_____
    postpartum recovery challenges and/or depression_____

    FOR MEN: __ urinary tract/ prostate difficulties ___ erectile dysfunction ___impotence

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FAMILY HEALTH HISTORY

Please identify if there is a family history of any of the following.
If yes, please indicate if the condition is yours or a family member's (E.g. father, grandmother, uncle).

		Self	Family Member(s) (describe)
ADHD	□ Yes □ No	_____	_____
Arthritis	□ Yes □ No	_____	_____
Alcohol/Substance Abuse	□ Yes □ No	_____	_____
Anxiety	□ Yes □ No	_____	_____
Bipolar Disorder	□ Yes □ No	_____	_____
Cancer	□ Yes □ No	_____	_____
Child Abuse	□ Yes □ No	_____	_____
Diabetes	□ Yes □ No	_____	_____
Depression	□ Yes □ No	_____	_____
Domestic Violence	□ Yes □ No	_____	_____
Eating Disorders	□ Yes □ No	_____	_____
High Blood Pressure	□ Yes □ No	_____	_____
Learning Disabilities	□ Yes □ No	_____	_____
Obesity	□ Yes □ No	_____	_____
Obsessive Compulsive Behavior	□ Yes □ No	_____	_____
Panic Attacks/Phobias	□ Yes □ No	_____	_____
PTSD	□ Yes □ No	_____	_____
Schizophrenia	□ Yes □ No	_____	_____
Suicide or Attempted Suicide	□ Yes □ No	_____	_____
Other	□ Yes □ No	_____	_____

				Cause of Death	**Year**
Mother's Name: _____	DOB ___/___/___	Living? □ Yes	□ No	_____	____
Father's Name: _____	DOB ___/___/___	Living? □ Yes	□ No	_____	____

Other family members: (siblings and/or children)

Name: _____Age____ □ M □ F Living? □ Yes □ No _____ ____

Name: _____Age____ □ M □ F Living? □ Yes □ No _____ ____

Name: _____Age____ □ M □ F Living? □ Yes □ No _____ ____

Name: _____Age____ □ M □ F Living? □ Yes □ No _____ ____

Name: _____Age____ □ M □ F Living? □ Yes □ No _____ ____

Name: _____Age____ □ M □ F Living? □ Yes □ No _____ ____

Name: _____Age____ □ M □ F Living? □ Yes □ No _____ ____

Thank you very much for taking the time to complete this questionnaire.
Please *bring all completed forms with you to our first session.*