Anne Smith, Ph.D.

Adult Intake Form

Name _____ Today's Date _____

What is your reason for coming to therapy now? _____

_____

Check all symptoms you currently have or have had within the last three months:

___anger
___excessive worry
___worthlessness
___poor concentration
___restlessness
___depressed/sad
___hopelessness
___sleep disturbance
___appetite changes
___eating issues
___phobias/fears
___easily fatigued
___headaches
___impulsive behavior
___irritability
___loss of interest
___low motivation
___social anxiety
___negativity
___body image issues
___obsessive thinking
___procrastination
___perfectionism
___panic attacks
___muscle tension
___low energy
___seasonal moodiness
___low self-esteem
___indecisiveness
___mania

Please list current stressors: _____

_____

Please list any major changes in your life over the past five years: _____

_____

Please check any condition(s) in a blood relative:

___alcoholism ___ drug abuse ___anxiety ___phobias
___bipolar disorder ___depression ___psychosis ___suicide
___trauma ___violence ___obsessive compulsive disorder

Please list all medical conditions: _____

_____

Have you been in therapy before? Yes _____ No _____

If yes, when? _____

For what problems? _____

_____

Was it helpful? If yes, why and if no, why not? _____

Have you ever been hospitalized for a mental condition? Yes _____ No _____

If yes, when and where? _____

Are you currently taking psychiatric medication(s)? Yes _____ No _____

If yes, what meds are you taking? _____

Please describe the quality of your relationship with your parents: _____

_____

Please describe the quality of your relationship with your siblings: _____

_____

If you have children, please describe the quality of your relationship with them: _____

_____

Please describe the quality of your relationship with your partner/wife/husband/current relationship: _____

Who do you go to for support/help? _____

_____

What is your occupation? _____

What are your primary sources of stress at work? _____

_____

Do you exercise regularly? Yes _____ No _____

Do you get a regular check-up? Yes _____ No_____

Do you drink alcohol? Yes _____ No _____

Do you smoke? Yes _____ No _____

Is there anything else you want me to know? _____