

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 in the past:

- | | | |
|---|---|---|
| <input type="checkbox"/> anger | <input type="checkbox"/> phobias/fears | <input type="checkbox"/> obsessive thinking |
| <input type="checkbox"/> excessive worry | <input type="checkbox"/> easily fatigued | <input type="checkbox"/> procrastination |
| <input type="checkbox"/> worthlessness | <input type="checkbox"/> headaches | <input type="checkbox"/> perfectionism |
| <input type="checkbox"/> poor concentration | <input type="checkbox"/> impulsive behavior | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> restlessness | <input type="checkbox"/> irritability | <input type="checkbox"/> muscle tension |
| <input type="checkbox"/> depressed/sad | <input type="checkbox"/> low motivation | <input type="checkbox"/> seasonal moodiness |
| <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> social anxiety | <input type="checkbox"/> low self-esteem |
| <input type="checkbox"/> appetite changes | <input type="checkbox"/> negativity | <input type="checkbox"/> indecisiveness |
| <input type="checkbox"/> eating issues | <input type="checkbox"/> body image issues | <input type="checkbox"/> 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:

- | | | | |
|---|-------------------------------------|--|----------------------------------|
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> drug abuse | <input type="checkbox"/> anxiety | <input type="checkbox"/> phobias |
| <input type="checkbox"/> bipolar disorder | <input type="checkbox"/> depression | <input type="checkbox"/> psychosis | <input type="checkbox"/> suicide |
| <input type="checkbox"/> trauma | <input type="checkbox"/> violence | <input type="checkbox"/> 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? _____

Do you want me to contact your prescribing physician? Yes _____ No _____

If yes, what is his/her name? _____

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? _____