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Under the supervision of Kate O'Hara Park, LPC Lic. # MO-2008035991

ADULT INTAKE FORM Today's Date: ___/___/_____

The information you provide will be kept confidential as outlined in the *Notice of Provider Privacy Practices*, which reflects state and federal regulations. Feel free to add any other information you feel may be useful. Please contact me with any concerns prior to completing this questionnaire or ask questions at any point in our work.

Demographics:

Name: _____ DOB: ___/___/_____ Age: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ May I leave you a message? ☐Yes ☐No

May I text message you to coordinate appointments? ☐Yes ☐No

Email: _____ May I email you? ☐Yes ☐No

Calls or emails will be discreet, but please indicate any restrictions: _____

Gender: ☐Male ☐Female ☐Transgender Ethnicity: _____

Marital Status: ☐Single ☐Cohabitating ☐Married (# of marriages: ___) ☐Divorced ☐Widowed

Highest Level of Education: _____ Are you employed? ☐Yes ☐No

Employer & Occupations: _____

School: _____

Were or are you a member of the armed services? ☐Yes ☐No If so, when? _____ What Branch? _____

Emergency Contact: _____ Phone and Relation to you: _____

Health Information:

Are you currently taking medications(s) for physical or psychiatric purposes? (Use back for extra space)

Name of medication & dosage	Purpose	Prescribing physician/psychiatrist
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you rate your current physical health? ☐Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good
Are you under a physician's care? ☐ Yes ☐ No Name & Phone number: _____
Are you under a dietitian's care? ☐ Yes ☐ No Name & Phone number: _____
Are you under a psychiatrist's care? ☐ Yes ☐ No Name & Phone number: _____

How is your sleep? ☐ Good ☐ Poor How many hours do you sleep per night? _____
How is your diet? ☐ Good ☐ Poor How many meals do you eat per day? _____

Do you exercise regularly? ☐ Yes ☐ No How many times per week? _____
Do you drink alcohol or use drugs? ☐ Yes ☐ No What, how much, and how often? _____
_____

Mental Health History:
Have you had previously attended counseling, psychotherapy, or psychiatry? ☐ Yes ☐ No
If yes: Reason you attended: _____ How was your experience? _____
When was your last appointment? _____ How come you stopped? _____
Have you ever been hospitalized for psychiatric purposes (i.e. severe depression, suicide risk, etc?) ☐ Yes ☐ No
If Yes: When: _____ Briefly explain circumstances: _____

Current Symptoms
Energy: ☐ Normal ☐ Increase ☐ Decrease ☐ Hyperactive
Concentration: ☐ Normal ☐ Decrease
Crying spells: ☐ Yes ☐ No How often? _____
Irritability: ☐ Yes ☐ No ☐ Anger outbursts ☐ Rages Risk of Harm to others: ☐ Yes ☐ No
Are there any firearms or other lethal weapons in your home? ☐ Yes ☐ No
Depression: ☐ None ☐ Mild ☐ Mild/Moderate ☐ Moderate ☐ Moderate/Severe ☐ Severe
Anxiety: ☐ None ☐ Mild ☐ Mild/Moderate ☐ Moderate ☐ Moderate/Severe ☐ Severe
Panic attacks: ☐ Yes ☐ No How often? _____

Are you currently suicidal? ☐ Yes ☐ No Do you have a plan? ☐ Yes ☐ No
Have you ever been suicidal? ☐ Yes ☐ No When? _____
Have you ever had a suicidal plan? ☐ Yes ☐ No What? _____
Have you ever made a suicide attempt? ☐ Yes ☐ No
Please explain: _____
_____

Family History (Please check if a family member has or had any of the conditions)
Mental illness: ☐ Yes ☐ No Who & nature of the problem: _____
Alcohol/drug problem: ☐ Yes ☐ No Who & nature of the problem: _____
Psychiatric treatment/hospitalization: ☐ Yes ☐ No Who & nature of the problem: _____
Suicide attempts: ☐ Yes ☐ No Who & nature of the problem: _____
Medical problems: ☐ Yes ☐ No Who & nature of the problem: _____
Sexual abuse: ☐ Yes ☐ No Who & nature of the problem: _____
Physical abuse: ☐ Yes ☐ No Who & nature of the problem: _____
Other pertinent family information: _____
_____

Concerns & Expectations:

What concerns brought you into therapy? Approximate date of onset: _____

_____

_____

_____

Why have you sought treatment now?

_____

_____

_____

What are your expectations for treatment?

_____

_____

_____

Do you have any concerns about beginning therapy? _____

How did you learn about my services? _____

May I contact your referral source and thank him/her/it? ☐ Yes ☐ No

Signature: _____ Date: _____