Barstow Acres Children's Center
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www.childrencenter.net

Adult Intake (ages 18+)

CLIENT INFORMATION		
Full Name: Name that you like to be called (nickname):		Relationship Status: □ Single □ Married □ Divorced □ Separated □ Widowed
Date of Birth: Age:	Sex: □ Male □ Female □ Trans □ Other	Driver's License Number: Car Model: License Plate #:
Occupation:		Monthly Income: Other Income:
Home Address w/ Zip Code:		
Employer/Company Name: Ok to mail to this address? □ Yes □ No	Email: Ok to email? □ Yes □ No (Please note email correspondence is not guaranteed to be confidential)	
Home Phone #:	Cell Phone #:	Work Phone #:
Ok to leave messages? □ Yes □ No	Ok to leave messages? □ Yes □ No	Ok to leave messages? □ Yes □ No
Have you previously attended therapy? □ Yes □ No What kind of therapy? Inpatient /Outpatient/ Other: _____	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending therapy?

BIOPSYCHOSOCIAL HISTORY
Presenting Problem(s)
In your own words, describe the current problems as you see them.

How long has this been going on?

On a scale of one to ten, how motivated are you to resolve this issue? _____

What would you like to accomplish in therapy?

1.

2.

3.

What are some of your strengths?

1.

2.

3.

MEDICAL HISTORY

Do you have any medical conditions?

Do you have any allergies?

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)

1.

2.

3.

4.

Any other medications or comments your therapist should be aware of regarding your physical/mental health?

Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Depressed Mood	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Changes in appetite	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Sleep Disturbances	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Change in Energy Level	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Decreased Concentration	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Worthless/Helpless Feelings	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Anxiety Symptoms/ Panic Attacks	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Bingeing/Purging	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Feelings of Guilt	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Obsessions/ Compulsions	□Yes	□ No	If "Yes", please describe:
Phobias/Intense fears	□Yes	□ No	If "Yes", please describe:
Hyperactivity	□Yes	□ No	If "Yes", please describe:
Are you having suicidal thoughts?	□Yes	□ No	If "Yes", do you have a plan of how you would commit suicide:
Do you have the means to carry out your plan?	□Yes	□ No	If "Yes", how would you do this?
Do you have access to a firearm?	□Yes	□ No	If "Yes", how is the weapon stored/secured?
Have you ever made a suicide attempt or been hospitalized for suicide?	□Yes	□ No	Describe: Date(s) of attempt(s):

Has anyone in your family attempted/completed suicide?	□Yes	□ No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a therapist or psychiatrist?	□Yes	□ No	If yes, please list the diagnosis and the years:

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No
Have you ever been arrested for a DUI, or drug use? Or do you have a past that involves using drugs or alcohol. Please briefly describe circumstances below:	□Yes	□ No

Family & Relationship History (Use reverse side of this page if you need additional space)

(Circle one)	**Age**	**Name**	**Living With You (Y/N)**	**Deceased (Y/N)**
Spouse/Partner	_____	_____	____	____

	Age	**Name**	**Living With You (Y/N)**	**Deceased (Y/N)**
Parent	_____	_____	____	____
Parent	_____	_____	____	____
Stepparent	_____	_____	____	____
Stepparent	_____	_____	____	____
Sibling	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
(Circle below)				
Children/Step	_____	_____	____	____
Children/Step	_____	_____	____	____
Children/Step	_____	_____	____	____
Children/Step	_____	_____	____	____

Are your parents divorced? □ Yes □ No **Remarried?** □ Yes □ No

Religion/Spirituality (if any) _____

Sexual orientation (please circle): Heterosexual Homosexual Bisexual Other: _____

Ethnic Group (select all that apply):

American Indian Alaskan Native Caucasian Middle Eastern

Asian Phillipino Native Hawaiian Pacific Islander Hispanic/Latino

Black/African American Multi-Ethnic/Other_____

Cultural Background/Considerations:

Is there anything about your cultural heritage/background that your therapist should be aware of?

Family of Origin (Circle Your Answer)

Have you experienced any abuse in your family or relationships?

None Emotional Physical Sexual Uncertain

In general, how happy were you growing up?

None Somewhat Mostly Extremely

How much is your family of origin a source of support for you?

None Somewhat Very Extremely

How much conflict in values do you experience with your parents?

None Somewhat Substantial

Legal Issues

Have you personally experienced legal problems? □ No □ Yes (describe)

Are you currently involved in a lawsuit? If so please describe:

Thank you for taking time to read and complete these questions. This information will be helpful in your therapy process. Your signature is required below before we can begin our work together. Please discuss any questions you may have with your therapist prior to signing.

- **I have thoroughly read and fully understand the Informed Consent and the therapy policy pages of this document.**
- **I understand that I am financially responsible for charges and fees incurred. I agree to honor the 24 hour cancellation policy.**
- **I understand limits of confidentiality and all mandated reporting by my therapist.**
- **I agree to respect the boundaries of contact between sessions and understand email and text is not an appropriate form of processing what is best discussed in session.**
- **I understand that emailing, texting and telephone communications are not guaranteed as confidential.**

Client's name (printed): _____

Client's signature: _____ Date: _____

Therapist's name (printed): _____

Therapist's signature: _____ Date: _____

Other notes: