P; 320-259-0749
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14 7th Ave N St Cloud MN 56303

Adult Intake Form

Name: ____ *Date:* _______________
(First) *(Middle Initial)* *(Last)*

Address: ____

Phone: _____________________________ *Email:* ___________________________ *Okay to email you? Y___N___*
Okay to leave a message via phone: ___Yes ___No *(Please make note of your session dates & times, reminder calls are not availabie at this time.)*

Emergency Contact: __________________________ *Relationship:* _______________ *Phone:* _______________
Gender: __F ___M ___Other Preferred Pronouns: ______________________________ *SS#:* ___________________

Concerns

Client Presenting Problems and Symptoms: ____

____

How long have you experienced these Problems/Symptoms: ____

____

Major Stresses or Changes in Your Life:

____

Suicidal:___Yes ____No **Homicidal:** ___ Yes ___ No

Strengths:

____

Client Concerns/Symptoms

	Yes	Comments
Depression or Sadness		
Loss of Interest in Daily Things		
Sleep Problems or Nightmares		
Appetite Changes		

	Yes	Comments
Disoriented or Confused		
Personality Changes		
Hallucinations		

Irritable or Short Tempered		
Withdrawn		
Fatigue or Low Energy		
Guilty Feelings		
Change in Activity Level		
Physical Complaints		
Self-Harming Behaviors		
Mood Swings		
Nervousness/Anxiety		
Panic Attacks		
Stressed		
Fears		
Obsessions/Compulsions		
Financial Problems		
Thoughts of Wanting to Die		
Chemical Use		
Cognitive Rigidity		
Sensory Issues		
Repetitive Thoughts/Behaviors		
Intrusive Memories		
Avoidance of Triggers		
Low Self Esteem		

Short Attention Span/Distractible		
Impulsive		
Cannot Sit Still		
Defiance		
Binging, Purging or Eating Concerns		
Excessive Concern with Appearance		
Aggression		
Legal Problems		
Other Dangerous Behaviors		
Family Problems		
Social Problems		
Sexual Behaviors or Problems		
Work or School Problems		
Negative Thoughts		
Speaking Noticeably Fast or Slow		
Language/Communication		
Ticks		
Body Image/Perception Issues		
Hyper Vigilance		
Racing Thoughts		
Nightmares/Flashbacks		
Psychosomatic		
Dissociation		

Medical/Psychiatric

Major Health Problems/Disabilities/Hospitalizations:

____

____

Known Allergies: ____________ ____________

Medication (Prescribed, Over The Counter, Herbal) Currently Used and Reason for Use:

____

____

Previous Mental HealthTreatment: ____

Family Mental/Physical Health History:

____

____

Prenatal History:

____

____

Addictions

Have you ever felt you ought to cut down on your drinking or drug use?	Yes No
Have people annoyed you by criticizing your drinking or drug use?	Yes No
Have you ever felt bad or guilty about your drinking or drug use?	Yes No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes No

Cigarettes?	Yes No
Caffeine?	Yes No
Drugs?	Yes No
Sexual?	Yes No
Alcohol?	Yes No
Gambling?	Yes No
Food?	Yes No
Other?	Yes No

Has previous addiction treatment been tried? Yes No

Are there addiction issues with family members? Yes No

Comments:

Family

Family Members:

____

____

____

Family Functioning & Stressors:

____

____

School (if applicable)

Name | Grade | Academic Grades | Learning Concerns:

____

____

Social

Peer Relationships/Friends Concerns:

____

Adjustments at School, Work or Community: ______________________________________

Cultural Influences/Impact: ____

Support System: ____

What goals do you have for therapy? ____

____

____

*Section Below for Therapist*____

Records Review Summary (if applicable):____

Behavioral Observations (if applicable):____

Diagnostic Impressions: ____

Diagnosis: ____

Recommendations and Plan: ____