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Adult Intake Form

Date _____

Family Information

	Name/Relationship	DOB	Contact: (* preferred)
Client			Home: Cell: Email:
Other			Home: Work: Cell: Email:
Other			Home: Work: Cell: Email:
Other			Cell:

Family Address (s)

_____

Street City Zip

_____

Street City Zip

Referred by_____ Phone_____

Name of Emergency Contact_____Relationship_____
Day Phone_____

Previous Therapy/Treatment? YES NO If yes,

When_____Where_____

With Whom_____Presenting Problem_____

Outcome_____

Medication or Medical Care_____

Presenting Problem (Why are you here?)

_____

_____

_____

_____

_____

_____

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_____

Chemical Dependency History (If applicable)

USED?	When First	Most Recent	How Much/Often	Method of Use
Marijuana	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Speed/Meth/Amphetimines	_____	_____	_____	_____

Cocaine/Crack	_____	_____	_____	_____
Benzodiazapenes (Valium,Xanax, Klonopin, etc)	_____	_____	_____	_____
Morphine (Heroin, Codiene, Vicodin, etc)	_____	_____	_____	_____
LSD, Ecstacy, Mushrooms	_____	_____	_____	_____
Other	_____	_____	_____	_____

How has substance use caused a problem?

1. Weight gain/loss	yes	no	7. Legal problems	yes	no
2. Vomiting after use	yes	no	8. Heart problems	yes	no
3. Blackouts	yes	no	9. Diabetes	yes	no
4. Attempts to control use	yes	no	10. TB	yes	no
5. Family problems	yes	no	11. Sight/hearing disability	yes	no
6. School problems	yes	no	12. Other_____		

Is there a history of physical, emotional, and/or sexual abuse? YES NO If YES, please explain:

_____

Have you ever considered suicide?_____

Suicide attempts?_____

How?_____When?_____

Number of attempts_____

Are you suicidal now? YES NO

If yes, do you have a method in mind? YES NO

What is it?_____

Have you ever been violent towards another person?

Explain_____

_____

Please list all prescription and over-the-counter medications you are currently taking or have taken in the past 30 days. (Include amount and frequency)

_____

_____

Are you the child of an alcoholic or addict? YES NO

Family of Origin History

Genetic family History: Alcohol, Nicotine, Drugs, Depression Suicide, and Eating Disorders

Family Member	Problem	Did they Receive Treatment?
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO

Other information you feel would be helpful: