Adult Intake Form

Please provide the following information below needed for our records. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session or email a copy prior to your appointment.

Client Information:

Name: _____

Age: _____ Birthdate (dd/mm/yyyy) _____ Gender: ___ M ___ F (Other: _____) Address: _____ City: _____ State: _____ Zip Code: _____ Home Phone: _____ okay to leave a voicemail: ___ yes ___ no

Work Phone: _____ okay to leave a voicemail: ___ yes ___ no Email: _____ okay to email a message: ___ yes ___ no

Emergency Contact: _____ Phone: _____

Relationship to you: _____

Company for LYRA benefits:_____

Marital Status (check all that apply):

___ Married ___ Single ___ Widowed ___ Partnered ___ Separated ___ Divorced

Please list any children and ages:

_____

_

_____

_

_____

_

How did you find out about us? _____

Referred by (if any): _____

Have you previously received any type of mental health services, such as counseling or psychiatric services? ___ yes ___ no (If yes, please list provider, dates, focus of the treatment, and reason treatment was terminated)

_____

_

_____

_

_____

_

Medical History:

Please list current and past prescription *psychiatric medication* that you are taking or have taken,

including dose and frequency:

_____
_
_____
_
_____
_

Please list current non-psychiatric prescriptions/medications (including other the counter and herbal supplements)

_____
_
_____
_
_____
_

Please list any current medical conditions:

_____
_
_____
_
_____
_

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

_____
_
_____
_
_____
_

Please check from the following list any items that you have experienced recently:

___ Loss of interest in activities ___ Overwhelming sadness
___ Crying often
___ Feeling hopeless
___ Anxiety, fears, worries
___ Frequent physical complaints ___ Significant change in weight ___ Trouble falling asleep or staying asleep ___ Racing or disorganized thought patterns ___ Thoughts of suicide
___ suicidal actions

Lifestyle Choices:

___ Irritability or anger ___ Mood shifts
___ Self-Mutilation
___ alcohol/drug abuse ___ Death of a loved one
___ Violence in the family ___ Sexual problems
___ Legal Problems
___ marital/relational problems ___ Parent/child conflict ___ Difficult changes

Do you smoke? ___ yes ___ no If yes, how much? _____ Do you drink alcohol? ___ yes ___ no If yes, how much? _____ Do you drink products containing caffeine? ___ yes ___ no If yes, how much? _____ Do you have any weapons in your home? ___ yes ___ no

Family History

What is your ethnicity and/or cultural heritage?

_____
_
_____
_
_____
_

Please list any medical (both physical and mental health – *such as schizophrenia, bipolar disorder, major depression*) conditions that exist within your family, as well as the family member with the condition:

_____
_
_____
_
_____
_

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

_____
_
_____
_
_____
_

Is there any history of suicide in your family? If so, please list:

_____
_
_____
_

Do you have any siblings? If so, please list with ages:

_____
_
_____
_
_____

_

Who do you turn to for support in your family?

_____

_

_____

_

Occupational and Social

Are you currently employed? ____ yes ____ no
if yes, what is your current occupation:

_____

_____

_

Do you enjoy your current profession? ____ yes ____ no
if no what would you change:

_____

_____

_

Please list any current legal troubles at this time, if any:

_____

_

_____

_

_____

_

What kind of activities or coping strategies (positive or negative) do you use when you are stressed or overwhelmed?

_____

_

_____

_

_____

_

What do you view to be your strengths as a person?

_____

_

_____

_

_____

_

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.

_____

_

_____

_

_____

_

_____

_

_____

_

_____

_

How would you describe your current level of functioning (please circle one):

(worst I've ever functioned) 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 (best I've ever functioned)

Any additional information you would like me to know?

_____

_

_____

_

_____

_

I have received and understand the office policies, informed consent, confidentiality, no secrets policy (couples and families only), text/email agreement, and HIPAA regulations in a verbal and written format:

X_____ date _____