Christina R. Perkins, LCSW
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Adult Intake Form

CLIENT INFORMATION

Client Name: _____ Today's date: ____/____/____
FIRST MI LAST

Social Security number: _____-_____-_____ Date of birth: ____/____/____ Gender Identity_____ Pronoun(s): _____

Address:_____
STREET APT.# CITY STATE ZIP

Permission to mail to this address? ☐ Yes ☐ No If no, please list permitted mailing address below:

_____
STREET APT.# CITY STATE ZIP

Home phone: (___)_____ Permission to contact you at this number? ☐ Yes ☐ No ☐ Messages

Cell phone: (___)_____ Permission to contact you at this number? ☐ Yes ☐ No ☐ Messages

Work phone: (___)_____ Permission to contact you at this number? ☐ Yes ☐ No ☐ Messages

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Cell phone: (___)_____ Work phone: (___)_____

_____
STREET APT.# CITY STATE ZIP

Permission to contact this person in emergency? ☐ Yes _____ ☐ No _____
Initials Initials

INSURANCE INFORMATION

If using insurance benefits, have you pre-authorized these visits through your insurance company?

☐ Yes ☐ No

Primary insurance company: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other: _____

Name of insured: _____ Insured's date of birth: ____/____/____

Copy of insurance card attached? ☐ Yes ☐ Not yet ☐ Not needed

Co-pay amount: $_____ Deductible amount: $_____ Deductible met? ☐ Yes ☐ No

HOW DID YOU HEAR OF THIS PRACTICE? _____

If referred, name of referent:_____ Relationship to you: _____

Phone: (___)_____ Permission to contact to thank for referral? ☐ Yes ☐ No

Form completed by: _____ Date:_____
☐ client ☐ legal guardian of client

PRESENTING PROBLEMS AND CONCERNS

Please describe the reason you are seeking therapy: _____

_____

_____

_____

Are you currently or do you have a history of being a sexual perpetrator: ☐ No ☐ Yes: _____

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Please check all of the following symptoms or factors that you are experiencing and consider to be problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure or interest
- ☐ Hopelessness
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories
- ☐ Thoughts of death*
- ☐ Self-harm/self-injury*
- ☐ Suicide attempt*
- ☐ Thoughts of harming someone else*
- ☐ Attempt to harm someone else*
- ☐ Being threatened by someone else*
- ☐ Being harmed by someone else*
- ☐ Witness to a traumatic event*
- ☐ Witness to violence*
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

If you checked any factor marked *, please describe all: _____

_____

_____

Which of the following areas of your life are or have been negatively affected by your symptoms?

- ☐ Handling everyday tasks
- ☐ Work/school
- ☐ Leisure activities
- ☐ Self-esteem/confidence
- ☐ Relationships
- ☐ Health/hygiene
- ☐ Legal matters
- ☐ Finances
- ☐ Other: _____

Please check if you have experienced any of the following:

- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Neglect
- ☐ Domestic violence
- ☐ Victim of other crime
- ☐ Witness to violence
- ☐ Parent/guardian's substance abuse
- ☐ Teen pregnancy
- ☐ Parent illness
- ☐ Adoption (either as parent or child)
- ☐ Foster care as a child
- ☐ Frequent family moves
- ☐ Homelessness
- ☐ Financial hardship/poverty
- ☐ Loss of a loved one
- ☐ Natural disaster
- ☐ Dangerous occupation (military, police, firefighter, EMT, etc.)
- ☐ Combat/front-line crisis experience
- ☐ Killing another person (in line of duty, self-defense, intentional other, or accidental other)
- ☐ Other: _____

MENTAL HEALTH TREATMENT HISTORY

Are you currently or have you ever undergone mental health treatment? ☐ No ☐ Yes
If yes, please answer the following:

List any previous mental health treatment experiences (including outpatient therapy, psychiatric treatment, residential, hospitalization, substance abuse treatment, and self-help and support groups:

Date	Provider/Agency	Reason for Treatment	Was It Helpful?
___/___/___	_____	_____	☐ Yes ☐ No
___/___/___	_____	_____	☐ Yes ☐ No
___/___/___	_____	_____	☐ Yes ☐ No

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Please describe what you did and did not like about your previous mental health treatment experience(s):

_____

_____

_____

_____

MEDICAL INFORMATION

What was the date of your last physical exam? ____/____/____ Do you have a Primary Care Physician (PCP)? ☐ No ☐ Yes:

PCP: _____ Phone: (___)_____
Permission to contact? ☐ Yes ☐ No

Are you currently under a physician's care for any medical condition? ☐ No ☐ Yes

Please Describe:_____

Physician: _____ Phone: (___)_____ Permission to contact? ☐ Yes ☐ No

Physician: _____ Phone: (___)_____ Permission to contact? ☐ Yes ☐ No

Physician: _____ Phone: (___)_____ Permission to contact? ☐ Yes ☐ No

Have you been diagnosed with any chronic medical conditions or terminal diseases? ☐ No ☐ Yes:

_____

Please list any prescriptions, vitamins or herbal supplements you are currently taking:

Name	Dosage/Frequency	Date 1st Prescribed	Prescribing Physician

Do you suffer from any allergies (including environmental, food, medication, or other)? ☐ No ☐ Yes:

_____

_____

Do you currently exercise? ☐ No ☐ Yes If so, how often and what type _____

_____

Do you currently work with a case manager? ☐ No ☐ Yes If so, where and what is their name_____

_____

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As mental and medical health can strongly impact one another, please check any medical conditions you have ever experienced:

- ☐ Fibromyalgia
- ☐ Chronic pain
- ☐ Chronic fatigue
- ☐ Asthma
- ☐ Breathing problems
- ☐ Dental problems
- ☐ Ear infections
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Dizziness
- ☐ High fever
- ☐ Nausea
- ☐ Vomiting
- ☐ Enlarged glands
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Neurological disorder
- ☐ Nose bleeds
- ☐ Seizures
- ☐ Paralysis
- ☐ Sleep disorder
- ☐ Stomach aches
- ☐ Digestive disorder
- ☐ Diarrhea
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Incontinence
- ☐ Constipation
- ☐ Kidney problems
- ☐ Ulcers
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Heart disease
- ☐ Blood clots
- ☐ Anemia
- ☐ Desire to lose weight
- ☐ Persistent weight loss without dieting
- ☐ Drastic weight gain
- ☐ Drastic weight loss
- ☐ Severe menstrual pain
- ☐ Irregular menstruation
- ☐ Menopause
- ☐ Abortion
- ☐ Miscarriage
- ☐ Enlarged prostate
- ☐ Erectile dysfunction
- ☐ Pains during sexual intercourse
- ☐ Other problems during intercourse
- ☐ Sexually transmitted disease: _____
- ☐ Tuberculosis
- ☐ HIV or AIDS
- ☐ Hepatitis
- ☐ Mononucleosis
- ☐ Measles
- ☐ Strep
- ☐ Chicken pox
- ☐ Mumps
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Polio
- ☐ Meningitis
- ☐ Cancer
- ☐ Multiple Sclerosis
- ☐ Lupus
- ☐ Arthritis
- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ Surgery
- ☐ Serious accident
- ☐ Head injury
- ☐ Other: _____

LEGAL INFORMATION

Have you ever been convicted of a misdemeanor or felony? ☐ No ☐ Yes: _____

_____

_____

Are you currently involved in a divorce or child custody dispute? ☐ No ☐ Yes: _____

_____

Are you currently involved in any other legal Issue? ☐ No ☐ Yes: _____

Do you have a probation/parole officer? ☐ No ☐ Yes: _____

_____

Do you consent to your parole/probation officer getting updates about your treatment? ☐ No ☐ Yes

SUBSTANCE USE HISTORY

Has substance use ever created problems in your life? ☐ No ☐ Yes: _____

_____

_____

Do you currently want to stop using any substance? ☐ No ☐ Yes: _____

_____

_____

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Have you ever experienced withdrawal symptoms when trying to stop using any substances? ☐ No ☐ Yes:

_____

_____

Do you believe that your substance use is creating problems with your work, relationships, health, or legal issues? ☐ No ☐ Yes:

_____

_____

Has anyone close to you ever told you that your substance use was creating problems with your work, relationships, health, or legal issues?

☐ No ☐ Yes: _____

_____

OCCUPATIONAL INFORMATION

Place of employment: _____ Job title/occupation: _____

Work address: _____
STREET APT.# CITY STATE ZIP

How long have you held this job? _____ How long have you been in this line of work? _____

Stress level of this position: ☐ Low ☐ Moderate ☐ High

Are you satisfied with your current workplace? ☐ Yes ☐ No: _____

Are you satisfied with your occupation/career? ☐ Yes ☐ No: _____

Do you currently have plans to change your career? ☐ No ☐ Yes: _____

What is your highest level of education? _____

Are you currently experiencing financial stress? ☐ No ☐ Yes: _____

FAMILY HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If applicable: Spouse's name: _____ Spouse's age: _____ Spouse's Gender: _____

Spouse's phone: (___)_____ Permission to contact? ☐ Yes ☐ No

Please complete the following information for all of your family members, including your parents/guardians, step-parents, siblings, current or ex-spouse(s)/partner(s), children, and any other significant family members:

Relationship to You	Name	Age	Quality of relationship	Currently Living in Your Household?
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

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				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

Check any of the following mental health concerns that you know or suspect a family member of dealing with:

Mental Health Issue	**Applicable Family Member(s)**	
☐ ADHD	_____	
☐ Child Abuse	_____	☐ Victim ☐ Perpetrator
☐ Depression	_____	
☐ Bipolar disorder	_____	
☐ Suicide (including unsuccessful attempts)	_____	
☐ Anxiety	_____	
☐ Panic attacks	_____	
☐ Obsessive-compulsive thoughts or behaviors	_____	
☐ Domestic violence	_____	
☐ Impulse control problems	_____	
☐ Eating disorder	_____	
☐ Schizophrenia	_____	
☐ Substance abuse	_____	
Type of Substance(s): _____		
☐ Other: _____	_____	

SOCIAL AND CULTURAL INFORMATION

Please list all the people in your life you believe you can count on for support:

Name	**Age**	**Relationship to You**	**Are You Able to Get in Touch with This Person Easily?**
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

How would you characterize how you get along with most people? (*check all that apply*):

☐ Affectionate	☐ Outgoing	☐ Aggressive	☐ Avoidant	☐ Submissive
☐ Polite	☐ Leader	☐ Argumentative	☐ Shy	☐ Other: _____

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Are you experiencing any problems related to your ethnic, racial, spiritual, gender, sexual orientation, or any other cultural or demographic affiliation? ☐ No ☐ Yes: _____

_____

Are you affiliated with a spiritual or religious group? ☐ No ☐ Yes: _____

LEISURE TIME & SELF-IMAGE

Please list all of your preferred hobbies and leisure activities, even if you are currently unable to participate in them:

Activity	How Often Do You Get to Participate in this Activity?	Are You Satisfied with the Amount of Time You Are Able to Commit to This Activity?

What do you believe are your greatest strengths? _____

_____

What do you need most in your life right now? _____

_____

What are your treatment preferences? _____

Is there anything else you believe is important that I did not ask and you would like to add? _____

_____

_____

***BY SIGNING BELOW**, I attest that the above information is accurate and give my consent for Christina R. Perkins, LCSW, to contact all of the persons, numbers and addresses I have authorized above verbally or in writing as necessary to my treatment. I understand that I can revoke this consent at any time in writing.

Client/Guardian Name:_____

Client/Guardian Signature: _____ Date: ____/____/____

Client/Guardian Signature: _____ Date: ____/____/____

Therapist Signature: _____ Date: ____/____/____