**Adult Intake Report**

**Chief Concern:**

Please describe the main difficulty that has brought you to see me:

**Primary Medical Care Provider (From whom or where do you get your medical care?):**

Clinic Name:

Phone:

Doctor's name:

Address:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?

No Yes

**Current Employer**

Employer:

Work Phone:

Address:

Occupation:

Length of time with this employer:

**Please indicate any restrictions on calls:**

**Present Relationships**

How do you get along with your spouse or partner?

How do you get along with your children?

**Past Psychological/Psychiatric Treatment**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

No Yes

Please indicate which type of treatment:

Inpatient Outpatient Both

**If yes, please indicate:**

When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems?

No Yes

**If yes, please indicate:**

When:

From Whom:

For What:

Results:

**List of Symptoms**

**Please check any of the following that have been bothering you lately:**

|  |  |
| --- | --- |
| abused as child agoraphobia alcohol use ambition anger anxiety appetite being a parent bowel trouble career choices children compulsions compulsivity concentration confidence depression divorce drug use/abuse | nervousness nightmares obsessive thinking overweight painful thoughts panic attacks phobias relationships sadness self-esteem separation sexual problems short temper shyness sleep stress suicidal thoughts work |
| eating problem education energy (hi/low) extreme fatigue fears fetishes finances friends guilt | headaches health problems inferiority feelings insomnia loneliness making decisions marriage memory my thoughts |

**Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:**

**Marriage / Relationship**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Family**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Job/School Performance**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Friendships**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Financial Situation**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Physical Health**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Anxiety level / nerves**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Mood**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Eating Habits**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Sleeping Habits**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Sexual Functioning**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Alcohol / Drug use**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Ability to Concentrate**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Ability to control anger**

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

**Substance Use**

Do you currently consume alcohol?

No Yes

**If yes, on average how many drinks per occasion do you consume?**

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol?

No Yes

Have family members or friends expressed concerns about your drinking?

No Yes

Do you currently use non-prescribed drugs or street drugs?

No Yes

Do you have a history of problematic use of prescription or non-prescription drugs?

No Yes

Do you have a family history of alcohol or drug problems?

No Yes

**If yes, please describe:**

**Other**

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use more paper if needed

**Disclosure Statement:**

I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part-2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to W Schaffer & Associates. Unless otherwise revoked, this consent expires in 12 months from this date. I understand that once information is disclosed per my authorization, the information may be redisclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

Signature: Date: