People In Need
Adult Intake Information Form
(18 years old and up)

Date: _____ Name: _____ Client Case # _____

Age: ___ Sex: ____ Date of Birth: _____ Social Security Number: _____-_____-_____

Home Address: _____

Work Address: _____

Employer: _____ Occupation: _____ Referred by: _____

Please contact me by: ☐ Home Phone: _____

☐ Cell Phone: _____

☐ Work Phone: _____

Emergency Contact Person: _____ Relation: _____

Phone: _____ Address: _____

Describe the reason for your visit:

_____

_____

_____

Family and Household Composition: (List all immediate family members/significant relationships. In *Location* column, write **H** for people living in your household and write city/state of residence for people not in your household. Under *Health Issues,* write any serious illness or injuries).

NAME	RELATIONSHIP	AGE	LOCATION	HEALTH ISSUES

Martial and Relational History:

☐ Never married ☐ In a current relationship, how long? _____

☐ Married Date: _____ ☐ Separated Date: _____ ☐ Divorced Date: _____

☐ Widowed Date: _____ ☐ 2nd Marriage Date: _____ ☐ 2nd Divorce/Separation Date: _____

Spouse/Partner Name: _____ Age: _____ Occupation: _____

Children? ☐ No ☐ Yes how many: _____

Please list any significant stressors that you have experienced (accidents, deaths, moves, job change/loss, illness, injury, family/marital problems, violence, crime, victimization, living arrangements):

_____

_____

_____

_____

Educational History:

Highest grade completed: _____ School: _____ Year: _____ ☐ Diploma ☐ GED

☐ Vocational training: _____ School: _____Year: _____

☐ College: Highest degree completed: _____ School: _____ Year: _____

☐ Military: Branch: _____ Dates: _____ Status: _____

Employment History:

EMPLOYER	JOB TITLE	LENGTH OF EMPLOYMENT	CURRENTLY EMPLOYED?

Have you ever been given warnings or let go from a job because of job performance? If yes, explain:

_____

Problems preventing you from maintaining steady employment: _____

_____

History of Sexual, Physical, or Psychological Abuse:

☐ Sexual abuse ☐ Raped ☐ Victim of domestic violence
☐ Physical abuse ☐ Psychological abuse ☐ Sexual activity with a family member or relative

Have you ever experience any kind of sexual, physical, or psychological abuse as a child, adolescent, or adult (describe nature of abuse, how long, age, people involved, charges filed/reporting of incident)?

_____

_____

_____

_____

Please list any previous MENTAL HEALTH SERVICES (residential, inpatient, partial, and/or outpatient):

PROVIDER/AGENCY	DATES	REASON

Please list any previous/current SUBSTANCE ABUSE TREATMENT services (inpatient, IOP, and/or outpatient):

PROVIDER/AGENCY	DATES	REASON

Please list any SYSTEMS INVOLVEMENT and/or intervention (social services, CYS, domestic relations):

TYPE OF INVOLVEMENT	DATES	OUTCOME

Please list any past and pending LEGAL MATTERS (criminal, DUI, civil, custody/visitation, divorce, disability):

LEGAL HISTORY	DATES	OUTCOME

_____ _____

Client Signature Date

Health Information

Primary Care Physician: _____ Height: _____ Weight: _____

Have you had any seizures or convulsions: ☐ No ☐ Yes, please explain when and what caused them:

_____

Allergies: ☐ No ☐ Yes, please list: _____

Current health problems or concerns:

PROBLEM/CONCERN	HOW LONG	NAME OF TREATING DOCTOR

Medical Hospitalizations (especially involving head/neck/spine):

FOR SURGERIES	OUTCOME/STATUS	DATE(S)

FOR MAJOR ILLNESS/INJURY	TREATMENT/OUTCOME	DATE(S)

Current Medications/Medications taken within the year (prescribed and non-prescribed):

MEDICATION	DOSE/FREQUENCY	REASON	SIDE EFFECTS

Family Psychiatric/Medical History (major illness or disease that runs in the family):

FAMILY MEMBER(S)	ILLNESS/DISEASE	TREATMENT	STATUS/OUTCOME

Immunization History:

IMMUNIZATION	DATE(S)	PROBLEMS/SIDE EFFECTS

Women Only:

Age you began to menstruate: ____ Explain any problems with menstruation: _____

Explain any menopause symptoms/treatment: _____

_____

	YES/NO	IF YES, HOW MANY	DATE(S)
Pregnancies			
Miscarriages			
Abortions			

Men Only:

List any problems with prostate/painful urination/impotence: _____

Lifestyle/Health Habits:

Hours of sleep per night: _____ Describe any sleep problems: _____

_____

Exercise/physical activities (how often, how long, what type):_____

_____

Describe any problems with appetite: _____

Any significant changes in weight (20+ lbs. in 6 months): ☐ No ☐ Yes, please describe and give any reasons for change: _____

Substance Use History (please check all past/present use):

Average daily consumption of coffee, tea, cola, or other caffeine: _____

☐ No tobacco use ☐ Former tobacco user who has quit, when: _____

☐ Tobacco user (cigarettes, cigars, chew, snuff, e-cig) Average daily tobacco use:_____

Depressants:

☐ Alcohol ☐ Barbiturates ☐ GHB ☐ Tranquilizers (Ativan, Valium, Diazepam, Librium, Xanax)

Age at first use: _____ Date of last use: _____ Frequency/length of use: _____

Method: _____ Quantity: _____

Stimulants:

☐ Methamphetamine ☐ Amphetamine (speed) ☐ Cocaine ☐ Crack

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Hallucinogens:

☐ LSD ☐ MDMA (ecstasy)

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Opiates:

☐ Heroin ☐ Methadone ☐ Morphine ☐ Suboxone ☐ Other Opiates (OxyContin, Percocet, Vicodin, etc)

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Other:

☐ Marijuana ☐ PCP ☐ Inhalants ☐ Steroids ☐ Over the Counter (cough syrup, caffeine, etc)

Age at first use: _____ Date of last use: _____ Frequency/length of Use: _____

Method: _____ Quantity: _____

Client/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____