MOUNTAINEER
PSYCHOLOGICAL SERVICES

ADULT/ADOLESCENT INTAKE FORM

Patient Name: _____Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Social Security Number:_____

Please briefly describe your presenting concern(s):

_____

_____

_____

_____

Please check all that apply and *CIRCLE* the main problem:

DifficultyWith:	Now	In thePast		DifficultyWith:	Now	In thePast		DifficultyWith:	Now	In thePast
Anxiety				Relationships (home, work, school)				Head Injury		
Depression				Blackouts				Nausea		
Mood Changes				Marriage/Partner				Dizziness		
Anger/Temper				Employment				Shortness of Breath		
Panic Attacks				Finances				Sweating		
Fears				Legal Problems				Muscle Tension		
Irritability				Sexual Problems				Heart Palpitations		
Concentration/ Attention				Child Abuse				Pain		
Careless Mistakes				Sexual Abuse				Speaking without thinking		
Headaches				Domestic Violence				Completing Tasks		
Memory				Thoughts of Hurting Self				Impulse Control		
Excessive Worry				Thoughts of Hurting Others				Dangerous Behavior		
Hyperactivity				Thoughts of Suicide				Grief/Loss		
Trusting Others				Sleep Problems				Changes in Appetite/Weight Loss or Gain		
Drugs				Nightmares				Body Image		
Alcohol				Stress				Binging or Purging		
Self-injurious Behavior				Parenting				Distressing Thoughts		

Motivation				Obsessive Thinking				Delusions, Hallucinations (hearing/ seeing things)		
High/Low Energy				Intrusive Thoughts				Beliefs that you have special powers		
Loss of Interest				Gambling				Bizarre/Unusual Experiences		

Family History: Please circle all that apply.

- Drug/Alcohol Problems
- Legal Trouble
- Domestic Violence
- Suicide
- Physical Abuse
- Sexual Abuse
- Hyperactivity
- Learning Disabilities
- Depression
- Anxiety
- Psychiatric Hospitalization
- Nervous Breakdown

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

_____

_____

_____

CURRENT MEDICATIONS:

Name of Medication	Dosage	Purpose	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke or use tobacco? YES NO If yes, how much per day? _____
Do you consume caffeine? YES NO If yes, how much per day? _____
Do you drink alcohol? YES NO If yes, how much per day/week/month/year? _____
Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If yes, what kinds and how often? _____

_____

_____

Have you ever been hospitalized for psychiatric reasons? (If yes, please list approximate dates and reasons):

_____

_____

_____

Have you ever talked with a psychiatrist, psychologist or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Relationship Status:

Currently in Relationship? _____ How Long? _____ Relationship Satisfaction: Poor ☐☐☐☐☐☐☐ Excellent
Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
Do you have children? _____ If yes, how many and what are their ages: _____

_____

Employment Status:

Working? _____ How long? _____ Job Satisfaction? Poor ☐☐☐☐☐☐☐ Excellent
Current Employer/Position: _____

Unemployed? _____ How long? _____

Previous employment/positions:_____

_____

Additional Information:

Are there any recent stressor or changes in your life or is there anything else that you think might be important for your therapist to know? (include abuse issues, moves, job loss or changes, divorce, illnesses, deaths, trauma, accidents, legal problems, drug or alcohol abuse in the family, or other major stressors)

_____

_____

_____

_____

How did you hear about our clinic?_____

_____

Contact/Billing Information:

Mailing address:_____

_____

_____

Best telephone number to reach you: _____ Is this a mobile / home / work line?

Insurance Carrier:_____

Policy Number:_____

Policy Holder's Name, Date of Birth, and Social Security number (if not you):_____

_____

_____

Emergency Contact Information:

Name: _____ Relation to you:_____

Phone Number:_____

Our clinic uses electronic mail for appointment reminders (typically ~24 hours in advance). Please provide an email address that you check regularly:

_____

What is your primary goal for today's visit?_____