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# Adult Intake Form

To help your clinician better understand your concerns, please complete the following information **at least 48 hours** prior to you initial appointment. Please submit your intake to Dr. Taylor using **the "e-mail link" located at the end of this form**. Of note, all information provided is confidential.

**Client's Legal Name:** _____ Preferred Pronoun: _____

Date of Birth and Age: _____ Today's Date: _____

Form Completed by: _____

## Presenting Problem(s)/Reason for Treatment

What is the main reason(s) you are seeking therapy today? _____

_____

_____

In what ways have these issues/events impacted your life? _____

_____

In what ways have these issues impacted your family? _____

_____

What are some goals you might have for yourself while in treatment? _____

_____

Did anyone refer you to Dr. Taylor? _____

If you were not referred, please tell us how you heard about Dr. Taylor?

_____

## Please Bold All that Apply:

| | | |
|---|---|---|
| ☐ Sad or unhappy most of the time | ☐ Inconsistent Following Directions | ☐ Sleeping Difficulties |
| ☐ Cries Frequently | ☐ Talks Back to Adults/Authority Figures | ☐ Overeating |
| ☐ Lack of Energy | ☐ Aggressive Behaviors | ☐ Decreased Motivation for Food Intake |
| ☐ Feelings of Worthlessness/Helpless | ☐ Temper Outbursts | ☐ Difficulty Concentrating |
| ☐ Apathy | ☐ Unmotivated | ☐ Impulsive Behaviors/Reactions |
| ☐ Negative Thinking | ☐ Runs Away from Home | ☐ Complaints of Aches and Pains |
| ☐ Angry/Irritated Easily | ☐ Often Swears | ☐ Bites Nails/Pulls own Hair |
| ☐ Loss of Previous Interests | ☐ Often Lies | ☐ Takes too Many Risks |
| ☐ Thoughts Self Harm or Suicide | ☐ Procrastinates | ☐ Negative Body Image |
| ☐ Vomiting | ☐ Social Withdrawal | ☐ Nervous Tics |

| | | |
|---|---|---|
| ☐ Immature | ☐ Energetic | ☐ Victim of Bullying |
| ☐ Sensitive to Criticism | ☐ Picks on other Kids | ☐ Irritable |
| ☐ Panic Attacks | ☐ Lonely | ☐ Victim of Cyberbullying |
| ☐ Afraid of Rejection | ☐ Anxious | ☐ Gets into Physical Altercations with Peers |
| ☐ Very Shy | ☐ Cruel to Animals | ☐ Isolates themselves |
| ☐ Rapid Mood Changes Without Cause | ☐ Perfectionist | ☐ Tries to Boss Peers |
| ☐ Restless | ☐ Few or No Friends | ☐ Overly Engaged in Video Games |
| ☐ Emotionally Numb | ☐ Fearful | ☐ Overly Engaged with Social Media |
| ☐ Optimistic | ☐ Doesn't Trust Others | ☐ Spends too much time Online |
| ☐ Poor Loser | ☐ Dating Problems | ☐ Lives in a Blended Family |

| | | |
|---|---|---|
| ☐ Child of Divorced Parents | ☐ Daydreams | ☐ Struggles with Concentration |
| ☐ Seeks out/needs a lot of Attention | ☐ Easily Bored | ☐ Easily Annoyed |
| ☐ Has been in Trouble with the Law | ☐ Seen as Different or Weird by Peers | ☐ Content with How Things Are |
| ☐ Drug Use Concerns | ☐ Hates Going to School | ☐ Afraid of Going to School |
| ☐ Alcohol Use Concerns | ☐ Learning Difficulties at School | ☐ Problems Completing/Turning in Homework |
| ☐ Steals | ☐ Skips School Often | ☐ Often Performs Below Ability in School |
| ☐ Victim of Physical Abuse | ☐ Victim of Emotional Abuse | ☐ Victim of Sexual Abuse |
| ☐ Has Difficulty with Pornography | ☐ Frequency Migraines/Headaches | ☐ Sees Things that Others Cannot See |
| ☐ Unable to Relax | ☐ Unable to Relax | ☐ Unable to Relax |

Are there any other concerns that are not listed above you would like to discuss/share? _____

_____

## Race (Optional)

**Mark Which Best Represents You Race:**

American Indian or Alaska Native ___ Caucasian (White) ___ Asian ___ Black or African American ___

Native Hawaiian or Other Pacific Islander ___ Two or More Races __ Other: _____

## Ethnicity (Optional)

**Mark Which Best Represents Your Ethnicity**:

**Hispanic or Latino** (Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) ___

**Non-Hispanic or Latino** ___

**Spanish Origin** ___

## Sexual Orientation (Optional)

**Mark Which Best Represents Your Identified Sexual Orientation**:

Heterosexual ___ Bicurious ___ Gay ___ Pansexual ___ Agender ___ Bisexual ___

Lesbian ___ Questioning ___ Androgyny/ous ___ Transgender ___ Demisexual ___

Third Gender ___ Asexual ___ Transitioning ___ Gender Fluid ___ Ze/Zir ___

Bigender ___ Queer ___ Intersex ___ Other _____

## Family Relationships

**Your Current Marital Status**:

Married __ Separated (included living common law) ___ Single (included living common law)

Divorced (included living common law) ___ Domestic Partner (including living common law) ___

Never Married ___ Widowed (included living common law) ___

**Please List any Family Member or Supportive Individual of Significance**:

| Name | Age | Relationship | Relationship Quality | Living with You |
|---|---|---|---|---|
| | | | Good __ Fair __ Poor __ | Yes __ No __ |
| | | | Good __ Fair __ Poor __ | Yes __ No __ |
| | | | Good __ Fair __ Poor __ | Yes __ No __ |
| | | | Good __ Fair __ Poor __ | Yes __ No __ |
| | | | Good __ Fair __ Poor __ | Yes __ No __ |
| | | | Good __ Fair __ Poor __ | Yes __ No __ |
| | | | Good __ Fair __ Poor __ | Yes __ No __ |

## Developmental History

**Where you Born**:

Premature (more than 2 weeks early) _____ Full Term (on time) _____ Late (how long) _____

Planned C-Section _____ Emergency C-Section_____

Any Complications at birth you can recall? (please list) _____

_____

**During Pregnancy** (mark all that apply):

High Stress ___ Illness ___ Hospitalization ___ Accidents ___ Domestic Violence/Trauma ___

Drug Use ___ Alcohol Use ___ Smoking (Cigarettes/Vaping etc.) ___ Chewing Tobacco ___

Bed Rest ___ Blood Loss ___ Gestational Diabetes ___ Other Illnesses: _____

**As a Toddler, did you Experience:** (mark all that apply)

Overly Active ___ Passive ___ Difficulty Separating from Parents ___ A Head Injury ___

Anxiety ___ Withdrawn ___ Sensitivity to: (clothing, light, texture, noise) ___ Nightmares ___

Any Change was Hard ___ Other: _____

## Medical History

Do you have allergies? If yes, please list. _____

_____

Physical and/or Psych Hospitalizations? If yes, please list when and where. _____

_____

Serious Accidents of any kind? _____

_____

History of Head Injury with Loss of Consciousness? _____

_____

History of Repeated Strep Infections? If yes, please describe._____

_____

Current Medications: _____

_____

Current Primary Care Provider (if any): _____

Attended Therapy previously? Please list Therapist, Location, Reason Ended. _____

_____

_____

Do you Experience Issues with Pain? _____

## Trauma History

**Have you Ever Been a Victim of Abuse or Trauma:** (mark all that apply)

Physical ___ Sexual ___ Bullying ___ Refugee Trauma ___ Medical Trauma ___

Emotional ___ Verbal ___ Neglect ___ National Disasters ___

Traumatic Greif ___ Community Violence ___ Terrorism and Violence ___ Other: _____

## Personal and Family Psychiatric History

Please list Family Member, Diagnosis/Symptoms, When:

| Family Member | Diagnosis/Symptoms | When |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Is there a Family History of Learning Disabilities, Attention Deficit Hyperactivity Disorder, or Developmental Disorders? If yes, please list. _____

_____

Family History of Mania? If known please list. _____

Family History of Substance Abuse? _____

_____

Family History of Suicide? (attempted and/or completed) _____

_____

## Personal Mental Health History:

Have you or do you currently engage in Self-Harm Behaviors? Please list method if comfortable doing so:

_____

Have you Expressed Thoughts of Suicide? If yes, please indicate when: _____

_____

Have you ever attempted Suicide? If yes, please indicate when and how: _____

_____

Have you ever Experienced Hallucinations and/or Delusions? Please Describe: _____

_____

## Substance Use History

**Do You Use**: (mark all that apply. If occasional use, please indicate how often)

Alcohol ___
Cocaine ___
Marijuana ___
Marijuana Eatables ___
CBD Oil ___
Opioids ___
(Hydrocodone, Vicodin, Oxycodone, Percocet, Morphine, Codeine, Fentanyl, etc.)
Synthetic Cannabinoids (K2/Spice) ___
Smoke Cigarettes ___
Vape ___
Chewing Tobacco ___
Stimulants Recreationally (Adderall/Ritalin) ___
Methadone ___
Benzos (Xanax, Klonopin, Valium, etc.) ___

## Systems

Average Hours of Sleep per night? _____ Do you Experience Nightmares? _____

More Challenging: (mark all that apply) To sleep ___ To Stay Asleep ___ To Wake up ___

Is your Bedtime Routine an Issue/Inconsistent? Please Explain: _____

_____

Recent Changes in Your: (mark all that apply) Mood ___ Eating Habits ___ Weight ___ Exercise ___

## Educational History

Highest or Current Grade Level Completed: _____

Have you previously been Diagnosed with a Learning Disability? _____

Current Employer: _____ How long? _____

Employment Status:

Full Time (30 hours or more) ___ Unemployed ___ Volunteer ___ Internship ___

Part Time (Less than 30 hours) ___ Retired ___ Other (list) _____

## Technology, Social Media and Video Game Play

**Currently, how many hours per day do you spend**:

Online (internet) ____ Playing Video Games ____ Watching YouTube ____ Watching TV ____

Streaming Movies/Shows (Netflix) ____ Using Social Media ____ Texting with Peers ___

Using Facetime ____

What Social Applications (Facebook, Instagram, Snapchat, etc.) do you use most? _____

_____

## Legal

Any legal history of note? (Past, current, pending)_____

_____

Any Custody Related Legal History? _____

Any Family Legal History of Note? _____

## Religious/Spiritual History

What religion or spiritual background do you ascribe to? Family ascribe to? _____

_____

How important is your religion and/or spiritual beliefs in your daily life? Family structure? _____

_____

## Military History

Any Family Military Service of note? If so, please identify branch of service:

| Family Member | Military Branch | Saw Combat |
|---|---|---|
| | | Yes __ No __ |
| | | Yes __ No __ |
| | | Yes __ No __ |
| | | Yes __ No __ |
| | | Yes __ No __ |

Lastly, is there any other information/concerns about you and/or your family you would like me to know that would assist in treatment? _____

_____

_____

Client Signature: _____ Date: _____

Click here to email

**Thank you in advance for taking the time to provide the above information!**