(404)-491-0340 info@kaleidoscopekid.com

Adult Intake Information Packet

Today's Date: _____

Client's Name: _____

Client's Date of Birth: _____ Client's Gender: _____

Current Age: _____ Marital Status: _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other

Home Address: _____

City/State/Zip: _____

May I send information to this address? Yes No
Home Phone _____ May I contact you at this number? Yes No

Cell Phone _____ May I contact you at this number? Yes No

Other Phone _____ May I contact you at this number? Yes No

If there are any further restrictions when calling, please explain: _____

_____

Email Address: _____
May I contact you via email? Yes No

Referred by: _____
May I have permission to thank this person for the referral? Yes No

Person to notify in case of an emergency: _____

Phone: _____

I will only contact this person if I believe it is a life or death emergency. Please provide your signature so I may do so: _____

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Please briefly describe your presenting concern(s): _____

_____

_____

What are your goals for therapy? _____

_____

_____

How long to you expect to be in therapy in order to accomplish these goals (or feel that you have the tools to be successful)? _____

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? _____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

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Previous medical hospitalizations (Include approximate dates and reasons):

_____

_____

_____

Previous psychiatric hospitalizations (Include approximate dates and reasons):

_____

_____

Have you ever been in therapy before or met with a psychologist, psychiatrist, or other mental health professional? If yes, please list approximate dates and reasons.

_____

_____

Education and Career

High School/GED___ College Degree___ Graduate Degree (or Higher)___ Vocational Degree___

What is your current employment?_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?_____

_____

What do you think are your strengths?_____

_____

_____

Relationships, Social Support, and Self Care

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships_____

Do you have children?____ If YES, how many and what are their ages:_____

_____

Describe any problems any of your children are having: _____

_____

Are there any other people living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life, and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

Legal Issues

Have the concerns you have today resulted in any legal issues? Yes No

If yes, please briefly describe: _____

_____

Are you currently involved in any lawsuits, custody battles, or other legal proceedings?
Yes No If Yes, please explain: _____

Is therapy a part of any court mandated requirement that you need to complete?
Yes No If Yes, please explain: _____

_____

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Are there other legal issues we should to be aware of? If so, please briefly describe.

_____
_____
_____
_____
_____
_____

_____

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Family Information

How would you describe your relationship with your mother?_____

_____

How would you describe your relationship with your father?_____

_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers or relatives who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

Siblings

Name	Age	Gender	Briefly describe relationship	Location

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Family History (Please think of all relatives, including parents, siblings, grandparents, aunts/uncles, cousins)

Issue	Who?	When?
Depression		
Anxiety		
ADD/ADHD		
Drug/Alcohol Abuse		
Suicide		
Physical Abuse		
Sexual Abuse		
Learning Disabilities		
Domestic Violence		
Bipolar Disorder		
Psychiatric Hospitalization		
Financial Distress		
Other mental health issues (please describe)		

Any other significant family information:

_____

_____

_____

_____

_____

_____

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Any additional information you would like to include:

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Please check all that apply……

Difficulty with	Now	Past	Difficulty With	Now	Past	Difficulty With	Now	Past
Anxiety			Allergies			Dizziness		
Depression			Divorce			Diarrhea		
Mood Changes			Seizures			Stomach Aches		
Anger			Cries Easily			Chest Pain		
Panic			Being Bullied			Sweating		
Fears			Bullying Others			Heart Problems		
Irritability			Loss of Memory			Muscle Tension		
Concentration			Blackouts			Disorganizatio n		
Headaches			Sexually Acting Out			Makes Careless		
Loss of Memory			Domestic Violence			Fidgets Frequently		
Excessive Worry			Thought of Har ming Others			Easily Disrupted by Noises		
Feeling Manic			Thoughts of Harming Self			People in General		
Trusting Others			Attempted Suicide			Completing Tasks		
Communica ting with			Thoughts of Suicide			Paying Attention		
Sexual Issues			Sleeping Too Much			Impulsive		
Alcohol/Drugs			Sleeping Too Little			Hyperactivity		
Eating Problems			Sleeping Alone			Fainting		
Severe Weight Gain			Nightmares			Hallucinations		
Severe Weight Loss			Falling Asleep			Head Injury		
History of Physical Abuse			Staying Asleep			Spouse/Partner		

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History of Sexual Abuse			**Making or Keeping Friends**			**Co-Workers**		