Adult Background Information Intake Form Date:

Full Name:______________________________Name you go by:______________________________
Address:__________________________City:________________State:________Zip:______________

Age:___________Date of Birth:__________ Race/Ethnicity:___________First language spoken: ____________

Phone numbers: (check preferred method of contact)

☐Home:_______________________________________Okay to leave message? ☐Yes No

☐Cell:_______________________________________Okay to leave message? ☐Yes ☐ No

☐Work:_______________________________________Okay to leave message? ☐Yes ☐ No

☐Email:____Okay to initiate contact by email? ☐Yes ☐ No

Emergency Contact: Who should be contacted in case of emergency?

Name:____________________Relationship:_________________Phone #:________________________

How were you referred? ____

Treatment Goals: Please describe what brought you into treatment and what you hope to accomplish:

Educational background:________________________Occupation:_______________________________
Shifts worked:___________________________Hours per week:_____________________________
Do you enjoy your work? ☐Yes ☐No If no, please explain: ______________________________

____

Is there anything stressful about your work? ☐Yes ☐ No If yes, please explain:_____________________

____

If not employed, how long since you last worked?________What caused you to stop working?_______________

Do you have any physical, emotional, or learning disabilities? ☐Yes ☐ No If yes, please describe:______________

Do you consider yourself to be a spiritual or religious person? ☐Yes ☐ No If yes, please describe your religion, faith, belief, and practice:

____

Please describe your sexual identity? ____

Family of origin information: Please describe how it was to grow up in your family:

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Mother/Primary Caregiver:

Education:______________________ Occupation:______________________
Shifts worked:______________________ Hours per week:______________________
Marital/Relationship history:______________________
Mental health/addiction treatment history:______________________
Legal history:______________________
Currently in contact? ☐Yes ☐ No If no, please explain: ______________________

Father/Primary Caregiver:

Education:______________________ Occupation:______________________
Shifts worked:______________________ Hours per week:______________________
Marital/Relationship history:______________________
Mental health/addiction treatment history:______________________
Legal history:______________________
Currently in contact? ☐Yes ☐ No If no, please explain: ______________________

Significant caregiver or relative:

Education:______________________ Occupation:______________________
Shifts worked:______________________ Hours per week:______________________
Marital/Relationship history:______________________
Mental health/addiction treatment history:______________________
Legal history:______________________
Currently in contact? ☐Yes ☐ No If no, please explain: ______________________

Significant caregiver or relative:

Education:______________________ Occupation:______________________
Shifts worked:______________________ Hours per week:______________________
Marital/Relationship history:______________________
Mental health/addiction treatment history:______________________
Legal history:______________________
Currently in contact? ☐Yes ☐ No If no, please explain: ______________________

Sibling (full, step, or half brother/sister):

Education:______________________ Occupation:______________________
Shifts worked:______________________ Hours per week:______________________
Marital/Relationship history:______________________
Mental health/addiction treatment history:______________________
Legal history:______________________
Currently in contact? ☐Yes ☐ No If no, please explain: ______________________

Sibling:

Education:______________________ Occupation:______________________
Shifts worked:______________________ Hours per week:______________________
Marital/Relationship history:______________________
Mental health/addiction treatment history:______________________
Legal history:______________________
Currently in contact? ☐Yes ☐ No If no, please explain: ______________________

Residence History: Please describe places lived, when, and with whom including any custody arrangements, if applicable:

Family of Creation: Please describe how you currently get along with family members:

What is your current relationship status? ______________________________

Spouse/Partner/Significant Other:

Education:______________________ Occupation:______________________
Shifts worked:______________________ Hours per week:______________________
Marital/Relationship history:______________________
Mental health/addiction treatment history:______________________
Legal history:______________________
Currently in contact? ☐Yes ☐ No If no, please explain: ______________________

Please list any biological children including child's name, age, and other parent:

1. ______________________ Living with you full time ☐Yes ☐ No
2. ______________________ Living with you full time ☐Yes ☐ No
3. ______________________ Living with you full time ☐Yes ☐ No

Please list any step-children including child's name, age, and other parent:

1. ______________________ Living with you full time ☐Yes ☐ No
2. ______________________ Living with you full time ☐Yes ☐ No
3. ______________________ Living with you full time ☐Yes ☐ No

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Social History

Do you have a best friend? ☐Yes ☐ No ____ If yes, length of friendship:____________

How many close friendships do you have?___________How many times per week do you socialize?______________________________

What types of social/recreational activities do you enjoy?___________________

Have you previously received any type of mental health services? ☐Yes ☐ No If yes, please provide names of practitioner and dates of services:____

Are you currently taking any prescription medications: ☐Yes ☐ No If yes, please list medications and prescriber:

____

____

Please list any previous hospitalizations for psychiatric or medical treatment:

____

Please list any significant health issues or previous accidents:

____

Have you ever thought about suicide? ☐Yes ☐ No

If yes, please answer the following questions:

When was the most recent time you thought of suicide?____

Did you ever have a plan or imagine how you would do it? ☐Yes ☐ No If yes, please explain:

____

Have you ever made a suicide attempt? ☐Yes ☐ No ________ If yes, please provide date? _____________________________________

Do you have access to any firearms? ☐Yes ☐ No If yes, describe types_____________________________________

Have you ever engaged in self-injurious behaviors? ☐Yes ☐ No If yes, please describe:_____________________________________

____

Who or what are your current support systems?

____

How often do you drink alcohol? Daily Weekly Monthly Infrequently Never

How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

List all substances recreational or problematic (including alcohol) that you currently use, or have used in the last year (indicate frequency and amount): ____

Have you, or anyone close to you, ever felt that you have an alcohol/drug problem? ☐Yes ☐ No

If yes, have you had any previous treatment for drug/alcohol abuse? ☐Yes ☐ No ____ If yes, where and when were you treated?

____

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Have you ever been the victim of verbal abuse ? ☐Yes ☐ No If yes, by whom:________________ Was abuse reported? ☐Yes ☐ No

Have you ever been the victim of physical abuse ? ☐Yes ☐ No If yes, by whom:________________ Was abuse reported? ☐Yes ☐ No

Have you ever been the victim of sexual abuse ? ☐Yes ☐ No If yes, by whom:________________ Was abuse reported? ☐Yes ☐ No

Have you ever been the perpetrator of abuse (verbal, emotional, physical, and/or sexual)? ☐Yes ☐ No

If yes, please describe: ____

In the section below, identify if there is a family history of any of the following. If yes, please write the family member's relationship to you in the space provided (Father, Uncle, Grandmother, etc.)

Alcohol/Substance Abuse_____________________________

Anxiety_____________________________

Depression_____________________________

Domestic Violence_____________________________

Eating Disorder/Issues w food_____________________________

Obsessive Compulsive Behaviors_____________________________

Schizophrenia_____________________________

Suicide (including attempts)_____________________________

Please circle any problem that pertains to you at the present time:

- Anger
- Drug use
- Fatigue
- Finances
- Friends
- My thoughts
- Nervousness
- Self-esteem
- Sexual abuse
- Shyness
- Sleep
- Unhappiness
- Education
- Isolation
- Ambition
- Appearance
- Concentration
- Parenthood
- Relaxation
- Sexual orientation
- Energy
- Children
- Legal matters
- Under/over eating
- Depression
- Sexual problems
- Suicidal thoughts
- Self-injurious behaviors
- Nightmares
- Health problems
- Making decisions
- Physical Abuse
- Inferiority
- Career Choices
- Self control
- Alcohol use
- Headaches
- Work
- Relationships
- Divorce
- Future
- Temper
- Age
- Anxiety
- Weight
- Memory
- Fears
- Other____________________

Circle anything that has happened to you in the past three years:

Death of spouse/ partner/ significant relationship
Death of family member
Major illness or injury to you
Major illness or injury to someone in your life
Relationship Change

Change in job status
Move to another state
Legal Issues
Financial Changes

Are you, or have you ever served, in any branch of the military? ☐Yes ☐ No ______If yes, please answer the following questions:

What branches of the military have you served:____

Do you have combat history? ☐Yes ☐ No If yes, please describe any injuries/treatments?____________________

Please describe any legal issues (past or current) including arrests and driving violations:

____

How would you rate your current physical health?
Poor Unsatisfactory Good Very Good

Please list any specific health concerns:____

How would you rate your current sleep habits?
Poor Unsatisfactory Good Very Good

Number of hours of sleep nightly:______________ How many times per week do you exercise?____________

Please list any difficulties or changes you are experience with appetite or eating patterns:

____

Are you currently experiencing overwhelming sadness, grief, or depression? ☐Yes ☐ No

If yes, for how long?_________ If yes, describe symptoms:______________________________________

Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐Yes ☐ No

If yes, for how long?_________If yes, describe symptoms:______________________________________

How would you rate your ability to concentrate?
Poor Unsatisfactory Good Very Good

Any recent weight loss or gain? ☐Yes ☐ No If yes, how much?__________________________

How would you rate your energy level?
Poor Unsatisfactory Good Very Good

Please list some of your personal strengths:

____

Please list some of your personal challenges:

____

Additional Information: ____

Name of Client (please print)_______________________________________Date of Birth______________

Signature____Date____________________

Name and relationship of parent, guardian, or personal representative completing this form (please print)

____

Signature of Parent, Guardian or personal representative