

ADULT INTAKE ASSESSMENT

Patient Name _____ Age: _____ D.O.B _____

Date: _____ Present at intake: _____

Referral Source: _____

____ Single ____ Married ____ Divorced Sexual Orientation _____

PRESENTING PROBLEM (What are your concerns)

PROBLEM/CONDITION INCLUDES: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Abuse/assault/
rape victim | <input type="checkbox"/> Self-damaging
behaviors | <input type="checkbox"/> Social/Interpersonal
problems |
| <input type="checkbox"/> Alcohol or Drug
problems | <input type="checkbox"/> Suicide
threat/attempt/d
anger | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Failure to respond
to prior Treatment | <input type="checkbox"/> Depressed/Anxious
Mood | <input type="checkbox"/> Eating Disorder |
| | <input type="checkbox"/> Educational
Problems | <input type="checkbox"/> Sexual Identity
Issues |
| | <input type="checkbox"/> Medical Problems | <input type="checkbox"/> Occupational
problems |
| | <input type="checkbox"/> Family problems | <input type="checkbox"/> Legal Problems |

MEDICAL CONDITION AND HISTORY:

Primary Physician:

Clinic:

Last Physical:

Current Illness or injuries? YES | NO _____

Current Medications? | YES | NO (List names and dosage) _____

Health History (include use of caffeine, smoking, eating habits): _____

Has patient had any problems with physical pain? Y N

How severe? (1 2 3 4 5 6 7 8 9 10)

MENTAL HEALTH/AODA TREATMENT HISTORY

Prior outpatient treatment? |Yes |No Prior Inpatient Treatment? |Yes |No

TREATMENT FACILITY	DATES	REASON, OUTCOME

Psychotropic Medications? |Yes |No (Name, dosage, and dates). _____

SUBSTANCE USE HISTORY AND PROBLEM BEHAVIORS

Have you been concerned about your AOD(alcohol and other drug) use? Y N

Have others been concerned about your AOD use? Y N

Has using AOD caused any problems for you? Y N

If AOD treatment prior AODA Treatment? Y N

Last use and amount of alcohol/drugs _____

Indicate and describe if any of the following are identified as problems: Gambling Pornography

Computer/Internet

Unhealthy Sexual Activity Compulsive Eating _____

HISTORY OF BEHAVIORS:

- Fire Setting
- Enuresis
- Encopresis Problems
- Cruelty to animals
- Gambling
- Assaultiveness
- Use of Weapons
- Gang Involvement
- School Refusal
- Temper Tantrums
- Sexualized Behaviors
- Breathing/Choking Games
- Eating
- Sexual Abuse of others
- Suicide Attempts
- Theft
- Vandalism
- Verbal Agress.
- Runaway

Other Significant History: _____

FAMILY MEMBERS

Relationship	Name	Age	Residence	Notes

Nature of Current Relationship with Family Members: _____

Special Care/Situations of Childhood: (Check any that apply)

- Adoption: Age _____
- Foster Care: Age & Duration _____
- In Patient Placement: Age & Duration _____
- Resided with relatives: Age & Duration _____
- Other (Specify) _____
- History of Past or Current Involvement with Patient Protective Services Staff: _____

Significant Childhood/Adult Stressors: (Check any that apply)

- Death of parent: Patient Age _____
- Death of Sibling: Patient Age _____
- Divorce: Patient Age _____
- Physical/Sexual abuse: Patient's age & Duration _____
- Domestic Physical Violence _____
- Family Alcoholism/Drug Abuse or Dependency: One Parent Both Parents Other

- Family Mental Health/Psychiatric Problems: _____

- Other Stressors: _____

PARENTING: (please answer the following)

What strengths and deficits do the parents identify about themselves? _____

What are the patient's perceptions of the parent's strengths and deficits? _____

What types of rules and consequences are employed by the caregiver? _____

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DEVELOPMENTAL HISTORY:

Did you experience any developmental problems as a child? ___No Yes

If yes please describe: _____

ACADEMIC INFORMATION:

School attended _____ Grade: _____

School Performance _____

Attendance Problems: No Yes _____

History of Behavior Problems at School? No Yes _____

Special Education Instruction: No Yes _____

SOCIAL/PEER GROUP INFORMATION:

Social Activities/Interests: _____

Support System: _____

Hobbies/Interests: _____

Religious Involvement: _____

Work Experience: _____

