SWEETWATER
COUNSELING CENTER

Adult Intake Form

PATIENT INFORMATION

Patient Last Name: _____First Name: _____

_____

Chief Concern

Please describe the main difficulty that has brought you to see me:

_____

Your medical care (From whom or where do you get your medical care?)

Clinic name: _____

Phone: _____

Doctor's name: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Present relationships

How long have you been married? _____

How do you get along with your spouse or partner?

_____

How many children do you have? _____

How many children live with you? _____

How do you get along with your children?

_____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

Yes No

Please indicate which type of treatment (check one): Inpatient Outpatient Both

If yes, please indicate:

When: _____

From Whom: _____

For What: _____

Results: _____

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When: _____

From Whom: _____

For What: _____

Results: _____

List of Symptoms

Please indicate any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes

finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Family:
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Job/school performance: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Friendships: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Financial situation: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Physical health: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Anxiety level / nerves: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Mood: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Eating habits: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Sleeping habits: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Sexual functioning: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Alcohol / drug use: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Ability to concentrate: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Ability to control anger: _____
1-No effect 2–Little effect 3–Some effect 4–Much effect 5–Significant effect 6-NA

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

_____

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.

Sign Here_____ _____
Patient Signature Date

Sign Here_____ _____
Parent/Guardian Signature Date