Neuropsych Associates

ADULT INTAKE FORM

Client Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Gender: _____ Male _____ Female

Race: (Please Mark) ☐ White (Non Hispanic), ☐ Black (Non Hispanic), ☐ Hispanic, ☐ American Indian or Alaskan Native, ☐ Asian, ☐ Native Hawaiian or Other Pacific Islander, ☐ Multi-Racial

Address: _____ City: _____

State: _____ County: _____ Zip Code: _____

Phone: Home _____ Cell _____ Work _____

Email Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Married: Yes _____ No _____ If yes, Name of Spouse: _____

Legal Guardian/Emergency Contact Information

(Mark all that apply) ☐ Self ☐ Same as Above ☐ Parent ☐ Other Relative ☐ Foster Parent ☐ DCM

Name: _____

Address if Different from Client): _____

Phone: Home _____ Cell _____ Work _____

Employer: _____ Occupation: _____

Employer's Address: _____

Primary Language at Home: _____ Religious Preference: _____

TREATMENT AUTHORIZATION

I hereby authorize NeuroPsych Associates to provide therapy, counseling, or other services as deemed necessary for the client named above.

_____ _____

Signature of Client or Guarantor Date

Client Name: _____

List Present Household Members

Name	Age	Relation

Who referred you to NeuroPsych Associates? _____

What problems do you wish to address in counseling?

- _____
- _____
- _____

List any problems or difficulties that would prevent you from attending counseling.

- _____
- _____
- _____

Have you received counseling or inpatient treatment before?

- When did problems begin? _____
- Where did problems occur? _____
- Please include time schedule of events _____
- Was the counseling/treatment effective? Yes _____ If "No" Please explain: _____
  _____

List Hobbies, Talents, Enjoyable/Volunteer Activities:

- _____ _____
- _____ _____
- _____ _____

List all Peer and Community Supports (i.e. Church, School, and Friends):

- _____ _____
- _____ _____
- _____ _____

Client Name: _____

SOCIAL HISTORY

- Place of birth (City, State): _____
- Did you have prenatal care? Yes _____ No _____
- How much did you weigh at birth? _____lbs. _____ oz.
- Were there any complications at birth? Yes _____ No _____
- At what age:
  - Walk? _____
  - Talk? _____
  - Toilet training? _____

Describe Childhood:

- Environment _____
- Family Life _____
- Moving History _____
- Friends _____

Family Relationships: (Describe your relationship with each immediate/extended family member)

- Mother:
  - Name: _____ Age: _____
  - Occupation: _____
  - Relationship: _____
- Father:
  - Name: _____ Age: _____
  - Occupation: _____
  - Relationship: _____
- Grandparents:
  - Names: _____ Ages: _____
  - Occupations: _____
  - Relationships: _____
- Siblings:
  - Name: _____ Age: _____
  - Occupation: _____
  - Relationship: _____
  - Name: _____ Age: _____
  - Occupation: _____
  - Relationship: _____
  - Name: _____ Age: _____
  - Occupation: _____
  - Relationship: _____
  - Name: _____ Age: _____
  - Occupation: _____
  - Relationship: _____

Relationship: _____

Client Name: _____

FAMILY HISTORY

Is there a family history of mental health problems? If yes, please explain.

- _____
- _____
- _____

Is there a family history of any legal problems? If yes, explain briefly.

- _____
- _____
- _____

PROBLEM BEHAVIORS CHECKLIST

Community	Yes	No	Comments, times per day/week/month
Shoplifting/stealing			
Damage to property			
Poor choice of friends			
Involvement with legal system			

Behavior towards Others	Yes	No	Comments, times per day/week/month
Verbal aggression			
Physical aggression			
Cruelty to animals			
Thoughts/threats of killing others			
Argumentative			
Poor peer relations			
Withdraws from others			
Others take advantage of			

Moods/Emotions	Yes	No	Comments, times per day/week/month
Depressed/sad			
Crying spells			
Fearfulness			
Worries			
Nervous/irritable			
Angry			
Mood swings			
Easily upset			
Low energy			
Does not show feelings			

Self-Harmful Behavior	Yes	No	Comments, times per day/week/month
Puts self in dangerous situations			
Hurts/cuts self intentionally			
Thinks/talks of hurting self			
Attempted suicide			

Client Name: _____

Thinking	Yes	No	Comments, times per day/week/month
Forgetful/looses things			
Has memory loss			
Imagines things that aren't there			
Expresses odd beliefs/thoughts			
Suspicious/mistrusts others			
Odd or repetitive behaviors			
Poor judgment			

Physical	Yes	No	Comments, times per day/week/month
Unusual body movement/sounds			
Vomiting			
Headaches			
Stomachaches			
Other physical complaints:			
Accident prone			
Health problems/concerns			
Nightmares			
Eat too much			
Eat too little			
Sleep too much/too little			

Sexual	Yes	No	Comments, times per day/week/month
Masturbates in public			
Touches others inappropriately			
Exposes self to others			
Sexual behavior with objects			
Sexual behavior with animals			
Interest in pornography			
Preoccupation with sex			
Sexual talk/gestures			
Promiscuity			

MEDICAL HISTORY

Allergies: Yes _____ No _____ List all known allergies (food, medicine, insects, etc.): _____
_____

Height: _____ Weight _____ lbs. General health: Good _____ Fair _____ Poor _____

Are you currently under the care of a doctor? Yes _____ No _____, state the condition being treated: ____
_____

Physician's Name: _____ Address: _____

Please list medications, if any, that you or other family members take and for what reason: _____
_____

Advance Directives: In case of an emergency and if you need to go to an area hospital, please indicate the hospital of your choice:
_____

Client Name: _____

MEDICAL CONDITIONS

Condition	Client	Family History (Parents, siblings, etc.)
Diabetes		
Stomach Ulcers		
Glaucoma		
Heart Trouble		
High Blood Pressure		
Nervousness		
Liver Disease		
Asthma/Emphysema		
Tumors		
Tuberculosis		
Kidney/Bladder Pain		
Bleeding Tendencies		
Rheumatism/Arthritis		
Thyroid Condition		
Anemia		
Seizures		
Gout		
Stroke		
Cancer		
Other		

Please mark any conditions/problems that apply:

- ☐ Dizziness
- ☐ Blackouts/seizures
- ☐ Ear drainage or pain
- ☐ Tired most of the time
- ☐ Lack of appetite/indigestion
- ☐ Lack of or unable to sleep
- ☐ Breathing difficulty
- ☐ Pregnancy
- ☐ Nausea/vomiting
- ☐ Nagging cough or hoarseness
- ☐ Sores that do not heal
- ☐ Recent weight change (+/- 10lbs in 30 days)
- ☐ Leg cramps/aches etc.
- ☐ Shaking hands, arms, legs
- ☐ Frequency/difficulty urinating
- ☐ Constipation or diarrhea
- ☐ Pain/stress
- ☐ Chills, fever, or night sweats

Other

_____

Please list past surgeries or major hospitalizations (include dates) _____

_____

Client Name: _____

SUBSTANCE ABUSE HISTORY

Drug	Age of Onset	Longest Period of Sobriety	Date of Last Use	Current Amount and Frequency of Use
Caffeine				
Tobacco				
Alcohol				
Sedatives				
Hallucinogens				
Pain Killers				
Inhalants				
Cannabis				
Cocaine (+ Method)				
Crack Cocaine				
Heroin (+ Method)				
Ecstasy				
Special K				
Prescription Meds				

Related Problems

Alcohol	Drugs	
☐	☐	Interpersonal Problems
☐	☐	Binges
☐	☐	Job Problems
☐	☐	Sleep Disturbances
☐	☐	Physical Withdrawal
☐	☐	Hangovers
☐	☐	Arrests
☐	☐	Blackouts
☐	☐	Medical Complications
☐	☐	Assaults
☐	☐	Passing Out
☐	☐	Seizures
☐	☐	Concern over Use
☐	☐	Changes in Tolerance
☐	☐	Inability to Stop
☐	☐	Preoccupied w/obtaining

History of Treatment Attempts

Alcohol	Drugs	
☐	☐	None
☐	☐	Stopped on Own
☐	☐	Attended OP Program
☐	☐	Attended IP Program
☐	☐	Attended 12-Step Program
☐	☐	Attended Self-Help Group

Self Perception of Use

Alcohol	Drugs	
☐	☐	None
☐	☐	Experimental
☐	☐	Occasional or Social
☐	☐	Problems Use
☐	☐	Psychological Dependence
☐	☐	Does Not Want to Stop
☐	☐	Addicted/Cannot Stop
☐	☐	Motivated to Stop

I verify that the above information is correct: _____ _____/_____/_____

Signature **Date**