BALTIMORE THRIVES, LLC
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Confidential

Adult Intake Form

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session.

Today's Date: ____/____/_____

Name: _____

Your Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female □ Transgender Sexual Preference: □ Men □ Women □ Both

Local Address: _____

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

***Please be aware that email might not be confidential.**

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □Yes □No If yes, for how long?_____

If yes, on a scale of 1-10 (10 = great), how would you rate the quality of your relationship? _____

Do you have children? □No □Yes If yes, how many?: ____Ages:_____

HEALTH INFORMATION:

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Primary Care Doctor:_____ Phone:_____

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

_____

Medications: _____

Hours per night you normally sleep _____ Are you having any sleep problems? □ No □ Yes
If yes, check applicable: □ Sleep too little □ Sleep too much □ Can't fall asleep □ Can't stay asleep

Do you exercise regularly? □ No □ Yes
If yes, how many times per week? _____ For how long? _____
If yes, what do you do?_____

Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Do you regularly use alcohol? □ No □ Yes If yes, what is your frequency?_____
□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never
If you checked any box other than "never," which drugs do you use?_____

Do you smoke cigarettes? □ No □ Yes If yes, how many cigarettes per day?_____

Do you drink caffeinated drinks? □ No □ Yes
If yes, # of sodas per day_____ # cups of coffee per day_____

Have you ever had a head injury? □ No □ Yes
If yes, when and what happened?_____

MENTAL HEALTH INFORMATION:

What prompted you to seek therapy or an assessment at the current time?

What are your overall goals for therapy?

In the last year, have you experienced any significant life changes or stressors?

Have you had previous psychotherapy? □No □Yes If yes, why/when?

Are you currently taking prescribed psychiatric medications (e.g., antidepressants or others)? □Yes □ No If Yes, please list names and doses:
_____

If No, have you been previously prescribed psychiatric medication? □Yes □No If Yes, please list names and dates:
_____

Are you hopeful about your future? □ Yes □ No

Are you having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

If yes, have you recently done anything to hurt yourself? □Yes □No

Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never", when did you have these thoughts?

Did you ever act on them? □Yes □No

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? □Yes □No
Have you previously had homicidal thoughts? □Yes □No
If yes, when?

Are you currently experiencing:			**Rating Scale 1-10 (10 =worst)** *Only rate the areas to which you say "yes"*
Depressed Mood or Sadness	**yes**	**no**	_____
Irritability/Anger	**yes**	**no**	_____
Mood Swings	**yes**	**no**	_____
Rapid Speech	**yes**	**no**	_____
Racing Thoughts	**yes**	**no**	_____
Anxiety	**yes**	**no**	_____
Constant Worry	**yes**	**no**	_____
Panic Attacks	**yes**	**no**	_____
Phobias	**yes**	**no**	_____
Sleep Disturbances	**yes**	**no**	_____
Hallucinations	**yes**	**no**	_____
Paranoia	**yes**	**no**	_____
Poor Concentration	**yes**	**no**	_____
Alcohol/Substance Abuse	**yes**	**no**	_____
Frequent Body Complaints (e.g., headaches)	**yes**	**no**	_____
Eating Disorder	**yes**	**no**	_____
Body Image Problems	**yes**	**no**	_____
Repetitive Thoughts (e.g., Obsessions)	**yes**	**no**	_____
Repetitive Behaviors (e.g., counting)	**yes**	**no**	_____
Poor Impulse Control (e.g., ↑ spending)	**yes**	**no**	_____
Self Mutilation	**yes**	**no**	_____
Sexual Abuse	**yes**	**no**	_____

Physical Abuse	**yes**	**no**	_____
Emotional Abuse	**yes**	**no**	_____

<u>Have you experienced in the past</u>: **<u>Rating Scale 1-10 (10 =worst)</u>**

Only rate the areas to which you said "yes"

Depressed Mood or Sadness	**yes**	**no**	_____
Irritability/Anger	**yes**	**no**	_____
Mood Swings	**yes**	**no**	_____
Rapid Speech	**yes**	**no**	_____
Racing Thoughts	**yes**	**no**	_____
Anxiety	**yes**	**no**	_____
Constant Worry	**yes**	**no**	_____
Panic Attacks	**yes**	**no**	_____
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Repetitive Behaviors (e.g., counting)	**yes**	**no**	_____
Poor Impulse Control (e.g., ↑ spending)	**yes**	**no**	_____
Self Mutilation	**yes**	**no**	_____
Sexual Abuse	**yes**	**no**	_____

Physical Abuse **yes** **no** **_____**

Emotional Abuse **yes** **no** **_____**

OCCUPATIONAL, FINANCIAL, EDUCATIONAL, & LEGAL INFORMATION:

Are you employed? □ No □ Yes Occupation: _____

If yes, who is your current employer/position? _____

If yes, are you happy at your current position?

_____

Please list any work-related stressors, if any: _____

_____

Do you have financial concerns? □ No □ Yes
If yes, please explain: _____

Are you currently in the military? □ No □ Yes Previously? □ No □ Yes

Highest level of education:_____

Do you have any legal concerns? □ No □ Yes
If yes, please explain:_____

FAMILY HISTORY:

Are your parents:

□ still together

□ divorced, when_____

□ remarried

□ unmarried

□ deceased, if yes whom_____ age at death_____

Number of siblings:_____ Ages:_____

Do you have good family support? □ No □ Yes From whom?

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		Family Member(s)
Depression	**yes/no**	_____
Bipolar Disorder	**yes/no**	_____
Anxiety Disorders	**yes/no**	_____
Panic Attacks	**yes/no**	_____
Schizophrenia	**yes/no**	_____
Alcohol/Substance Abuse	**yes/no**	_____
Eating Disorders	**yes/no**	_____
Learning Disabilities	**yes/no**	_____
Trauma History	**yes/no**	_____
Suicide Attempts	**yes/no**	_____
Psychiatric Hospitalizations	**yes/no**	_____

ADDITIONAL INFORMATION:

What role, if any, do religion and/or spirituality play in your life?

Are you satisfied with your social situation/interpersonal relationships? □ No □ Yes

Please explain:

What do you consider to be your strengths? What do you like most about yourself?

What are effective coping strategies you use when stressed?

Is there anything that I did not ask about here that would be important for me to know about you?

How did you learn about me?