Ascend Psychiatry and Wellness Consulting Group
2100 Southbridge Parkway #650
Birmingham, Al 35209
ADULT INTAKE FORM.

DEMOGRAPHICS **Date**_____/_____/_____

Name _____ Date of Birth____/____/_____ Age _____

Gender ☐Female ☐Male ☐Other (specify) _____

Sexual Orientation ☐Straight/ Heterosexual ☐Gay, Homosexual, Lesbian, Bisexual ☐Other (specify)_____

Describe Your Ethnicity

☐Decline

☐ Alaska Native/American Indian – tribe _____

☐ Asian ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐White/Caucasian

☐ Other (specify) _____

Form completed by (if someone other than client) _____

If you need any more space for any of the questions below please use the blank back page.

PRIMARY REASON(S) FOR SEEKING SERVICES:

☐ Anger Management	☐ Depression	☐ Mental confusion	☐ Alcohol/drugs
☐ Anxiety	☐ Eating Disorder	☐ Sexual Concerns	☐ Addictive behaviors
☐ Coping	☐ Fear/phobias	☐ Sleeping problems	

Other mental health concerns (specify): _____

What are your goals for therapy?

Do you feel suicidal at this time? ☐ Yes ☐ No If yes, explain:

Please check behaviors and symptoms that occur more often than you would like them to:

- ☐ Aggression/Anger
- ☐ Alcohol dependence
- ☐ Antisocial behavior
- ☐ Anxiety/Panic Attacks
- ☐ Avoiding people
- ☐ Chest pain/heart palpitations
- ☐ Cyber addiction
- ☐ Depression
- ☐ Disorientation/Dizziness
- ☐ Distractibility
- ☐ Drug dependence
- ☐ Eating Disorder
- ☐ Elevated Mood
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ High blood pressure
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness/withdrawing
- ☐ Memory impairment
- ☐ Mood Shift
- ☐ Phobias/Fears
- ☐ Recurring/disorganized thoughts
- ☐ Sexual difficulties/addiction
- ☐ Sick often
- ☐ Sleeping problems
- ☐ Suicidal thoughts
- ☐ Trembling
- ☐ Worrying/hopelessness
- ☐ Other (specify) _____

Briefly discuss how the above symptoms impair your ability to function effectively:

_____

Any additional information that would assist us in understanding your concerns or problems:

_____

What are your goals for therapy?

_____

Do you feel suicidal at this time? ☐ Yes ☐ No If yes, explain:

FAMILY INFORMATION/PSYCHOSOCIAL HISTORY

Relationship	Name	Age	Living		Living with you	
			Yes	**No**	**Yes**	**No**
Mother	_____	_____	☐	☐	☐	☐
Father	_____	_____	☐	☐	☐	☐
Spouse	_____	_____	☐	☐	☐	☐
Children	_____	_____	☐	☐	☐	☐
Children	_____	_____	☐	☐	☐	☐

Significant others (e.g.), brothers, sisters, grandparents, step-relatives, half-relatives. (Please specify relationship.)

DEVELOPMENT

Are there special, unusual or traumatic circumstances that affected your development? ☐Yes ☐No

If yes, please describe: _____

_____

History of abuse? ☐Yes ☐No If yes, which type(s)? ☐Sexual ☐Physical ☐Verbal ☐Emotional

If yes, was the abuse as a: ☐Victim ☐Perpetrator

Childhood issues? ☐Neglect ☐Inadequate nutrition Other (specify):_____

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you

Had nightmares about it or thought about it when they did not want to?	☐ Yes ☐ No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐ Yes ☐ No
Were constantly on guard, watchful, or easily startled?	☐ Yes ☐ No
Felt numb or detached from others, activities, or your surroundings?	☐ Yes ☐ No

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (Please check all that apply)

☐ Affectionate	☐ Aggressive	☐ Avoidant	☐Leader
☐ Follower	☐ Friendly	☐ Fight/argue often	☐ Outgoing
☐ Shy/withdrawn	☐ Submissive	Other (specify): _____	

Sexual dysfunction: ☐Yes ☐No If yes, describe: _____

Any current/history of being a sexual perpetrator? ☐Yes ☐No

If Yes, describe: _____

CULTURAL/ETHNIC

Are you experiencing any problems due to cultural or ethnic issues? ☐Yes ☐No

If yes, describe: _____

Other cultural/ethnic information: _____

EDUCATION

Years of Education: _____ Currently enrolled in school? ☐Yes ☐No ☐High school graduate/G.E.D.

☐ Vocational	No. of years:_____	Graduated: ☐Yes	☐No	Major _____
☐ College	No. of years:_____	Graduated: ☐Yes	☐No	Major _____
☐ Graduate	No. of years:_____	Graduated: ☐Yes	☐No	Major _____

Other training: _____

Special Circumstances (e.g., learning disabilities, gifted): _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ☐Not ☐Little ☐Somewhat ☐ Very

Are you affiliated with a spiritual/religious group? ☐Yes ☐ No If yes, describe: _____

Were you raised within a spiritual/religious group? ☐Yes ☐ No If yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐Yes ☐No

LEGAL

Are you involved in any active cases (traffic, civil, criminal?) ☐Yes ☐No

If yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Past History: Traffic violations: ☐Yes ☐No DWI, DUI, etc: ☐Yes ☐No
Criminal involvement: ☐Yes ☐No Civil Involvement: ☐Yes ☐No

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason you left job	How often did you miss work?

Currently employed: ☐FT ☐PT ☐Temp ☐Laid off ☐Disabled ☐Retired

☐ Social Security ☐Student Other: _____

MILITARY

Military experience? ☐Yes ☐No Combat experience? ☐Yes ☐ No

Where:_____ Branch: _____

Rank at discharge: _____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, travel, etc.)

Activity	How Often?	How often in the past?

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric	☐	☐	_____	_____
Your reaction to overall experience	_____			
Suicidal thoughts/attempts	☐	☐	_____	_____
Your reaction to overall experience	_____			
Drug/alcohol treatment	☐	☐	_____	_____
Your reaction to overall experience	_____			
Hospitalizations	☐	☐	_____	_____
Your reaction to overall experience	_____			
Involvement with self-help Groups (e.g., AA, AL-ANON, NA, OA)	☐	☐	_____	_____
Your reaction to overall experience	_____			

Information about family/significant others (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Tx	☐	☐	_____	_____
Suicidal thoughts/attempts	☐	☐	_____	_____
Drug/alcohol treatment	☐	☐	_____	_____
Hospitalizations	☐	☐	_____	_____
Involvement with self-help Groups (e.g., AA, AL-ANON, NA, OA)	☐	☐	_____	_____

MEDICAL/PHYSICAL HEALTH

- ☐ AIDS
- ☐Alcoholism
- ☐Abdominal pain
- ☐Abortion
- ☐Allergies
- ☐Anemia
- ☐Appendicitis
- ☐Arthritis
- ☐Asthma
- ☐Bronchitis
- ☐Bedwetting
- ☐Cancer
- ☐Chest pain
- ☐Chicken Pox
- ☐Chronic pain
- ☐Colds/Cough
- ☐Constipation
- ☐Dental problems
- ☐Diabetes
- ☐Diarrhea
- ☐Dizziness
- ☐Drug abuse
- ☐Ear infections
- ☐Eating problems
- ☐Epilepsy
- ☐Fainting
- ☐Fatigue
- ☐Frequent urination
- ☐Headaches
- ☐Hearing problems
- ☐Hepatitis
- ☐High blood pressure
- ☐Kidney problems
- ☐Measles
- ☐Menstrual pain
- ☐Miscarriages
- ☐Mononucleosis
- ☐Mumps
- ☐Nausea
- ☐Neurological disorders
- ☐Nose bleeds
- ☐Pneumonia
- ☐Rheumatic Fever
- ☐Scarlet Fever
- ☐Sexual problems
- ☐Sexually transmitted diseases
- ☐Sinusitis
- ☐Sleeping disorders
- ☐Smallpox
- ☐Sore throat
- ☐Stroke
- ☐Thyroid problems
- ☐Tonsillitis
- ☐Toothache
- ☐Tuberculosis
- ☐Vision problems
- ☐Whooping cough

Other (describe): _____

_____

_____

CURRENT MEDICAL CONCERNS:

Please check if there have been any recent changes in the following:

☐ Sleep patterns ☐ Eating patterns ☐ Behavior ☐ Energy

☐ Physical activity ☐ General disposition ☐ Weight ☐ Nervousness/tension

Describe changes in areas in which you checked: _____

List any recent health or physical changes: _____

	Date	Reason	Results
Most recent examinations:			
Last physical exam	_____	_____	_____
Last doctor visit	_____	_____	_____
Last vision/hearing exam	_____	_____	_____
Most recent surgery	_____	_____	_____

Family history of medical problems: _____

MEDICAL HISTORY:

Current prescribed medications	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ☐Yes ☐No If yes, describe: _____

SUBSTANCE USE HISTORY

Do you have any current/historical substance or alcohol use? ☐ **Yes** ☐ **No** **If Yes:**

Have you ever felt you ought to cut down on your alcohol or substance use? ☐ Yes ☐ No

Have people annoyed you by criticizing your alcohol or substance use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your alcohol or substance use? ☐ Yes ☐ No

Have you ever used alcohol or substances first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you smoke, vape, or chew? ☐ Yes ☐ No

Do you use pain medication? ☐ Yes ☐ No

Please indicate below which substances you have used (if any):

☐ Alcohol	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Marijuana	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Cocaine/crack	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Meth/Amphetamine	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Heroin	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Other opiates	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Synthetics	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Inhalants	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Benzos	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Hallucinogens	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Over the counter	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Other:_____	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used
☐ Nicotine	_____Age of first use	_____# of days used in the last 30 days	_____Amount Used

Is there a history of Injection Drug Use? ☐Yes ☐No

If yes, Are you currently on MAT? ☐Yes ☐No

What is the date of your most current use:_____/_____/_____ Substance _____

Amount _____

Does your use affect your family and/or friends? ☐ Yes ☐ No If yes, describe: _____

Do you use alcohol or substances to cope with mental health issues or other stressors? ☐ Yes ☐ No

Have you increased your alcohol or substance intake in the last six months? ☐ Yes ☐ No

Does anyone in your family have current/historical alcohol or substance use? ☐ Yes ☐ No
If yes, describe:

Family member: _____ Substance/Alcohol _____ Current/historical _____

Have you ever experienced withdrawal symptoms, had an adverse reaction to, or overdosed on alcohol or substances?

☐ **Yes** ☐ **No** **If yes,** ☐ **Withdrawal** ☐ **Adverse reaction** ☐ **Overdose**

Describe: _____

Do you believe that your alcohol or substance use has created problems in your life, job, and/or relationships?

☐ **Yes** ☐ **No** **If yes, describe:** _

PLEASE USE THIS PAGE FOR ANY ADDITIONAL INFORMATION THAT YOU FEEL IS IMPORTANT TO ADDRESS :

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please complete, print, and bring to your appointment.