



## ADULT INTAKE FORM

Full Name: \_\_\_\_\_ Gender:  Male  Female  
Date of Birth: \_\_\_\_\_  Nonbinary  
Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ day/evening OK to leave msg?  Yes  No  
Work Phone: \_\_\_\_\_ day/evening OK to leave msg?  Yes  No  
Cell Phone: \_\_\_\_\_ day/evening OK to leave msg?  Yes  No  
Email: \_\_\_\_\_

Referred by (Name/Agency): \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### SCHOOL/EMPLOYMENT (if applicable)

Current School/College: \_\_\_\_\_ Grade/year: \_\_\_\_\_  
Highest Educational Level completed (circle): 8 9 10 11 12 13 14 15 16 17 18 19+  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ For how long? \_\_\_\_\_

### Marital Status

Single  Involved  Cohabiting  Engaged  
 Married  Separated  Widowed  Divorced

Please describe your ethnic background: \_\_\_\_\_

Please describe your current living situation: \_\_\_\_\_

Names and ages of your immediate family members:

Name: \_\_\_\_\_ Age: \_\_\_\_ Relationship to you: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_ Relationship to you: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_ Relationship to you: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_ Relationship to you: \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

### REASON FOR VISIT

Briefly describe your primary concerns and why you are seeking evaluation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FAMILY SITUATION

Relationship Status of Parents:

Cohabiting  Married  Separated  Divorced  Widowed  Remarried

Parent #1 Racial/Ethnic Background: \_\_\_\_\_

Parent #2 Racial/Ethnic Background: \_\_\_\_\_

Parent #1 Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: \_\_\_\_\_

Parent #2 Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: \_\_\_\_\_

### FAMILY HISTORY

List any *immediate or extended family members* with a history of concerns in the areas listed below. Please indicate their relationship to you and provide more detailed information, such as specific diagnosis. There is additional space on the final page if needed.

#### Chronic Physical Health Issues

Past: \_\_\_\_\_

Present: \_\_\_\_\_

#### Mental Health Concerns

Past: \_\_\_\_\_

Present: \_\_\_\_\_

#### Learning and/or Attention Concerns

Past: \_\_\_\_\_

Present: \_\_\_\_\_

#### Developmental Delay and/or Autism Spectrum Disorders

Past: \_\_\_\_\_

Present: \_\_\_\_\_

#### Drug/Alcohol Dependence or Abuse

Past: \_\_\_\_\_

Present: \_\_\_\_\_

**Physical/Sexual Abuse and/or Neglect**

Past: \_\_\_\_\_

Present: \_\_\_\_\_

**Domestic Violence**

Past: \_\_\_\_\_

Present: \_\_\_\_\_

**MEDICAL HISTORY**

How is your general health?     Excellent     Good     Fair     Poor

When was your last comprehensive medical evaluation? \_\_\_\_\_

List any serious illnesses for which you required hospitalization or surgical operation:

Illness: \_\_\_\_\_ Year: \_\_\_\_ Doctor/Hospital: \_\_\_\_\_

Illness: \_\_\_\_\_ Year: \_\_\_\_ Doctor/Hospital: \_\_\_\_\_

Illness: \_\_\_\_\_ Year: \_\_\_\_ Doctor/Hospital: \_\_\_\_\_

Are you currently taking any medications/supplements/vitamins?     Yes     No

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_ Prescriber: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_ Prescriber: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_ Prescriber: \_\_\_\_\_

Supplement/Vitamin: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

Supplement/Vitamin: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

List previous or current counseling, substance abuse services, psychiatric services, hospitalizations for mental health reasons, or psychological, speech/language, or occupational therapy assessment or services.

Service: \_\_\_\_\_ Year Started: \_\_\_\_\_ Currently receiving services?     Yes     No

Doctor/Therapist/Agency: \_\_\_\_\_

Service: \_\_\_\_\_ Year Started: \_\_\_\_\_ Currently receiving services?     Yes     No

Doctor/Therapist/Agency: \_\_\_\_\_

Service: \_\_\_\_\_ Year Started: \_\_\_\_\_ Currently receiving services?     Yes     No

Doctor/Therapist/Agency: \_\_\_\_\_

Service: \_\_\_\_\_ Year Started: \_\_\_\_\_ Currently receiving services?     Yes     No

Doctor/Therapist/Agency: \_\_\_\_\_

Please review the following checklist and place a "C" next to any **current** concern and a "P" next to any **past** concern. Current issues are those which have been present sometime within the past year, and a past concern is regarded as a year or more prior.

<b>Attention/Educational Issues</b>	<b>Developmental/Medical Issues</b>	<b>Emotional/Behavioral Issues</b>
<input type="checkbox"/> Inattention	<input type="checkbox"/> Speech delay/problems	<input type="checkbox"/> Verbal aggression/defiance
<input type="checkbox"/> Organizational difficulties	<input type="checkbox"/> Fine/Gross motor delay	<input type="checkbox"/> Difficulty managing anger
<input type="checkbox"/> Academic delays/concerns	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Physically aggressive
<input type="checkbox"/> Memory concerns	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Sexualized behavior
<input type="checkbox"/> Peer conflict/bullying	<input type="checkbox"/> Bedwetting/bowel problems	<input type="checkbox"/> Low self-esteem
<input type="checkbox"/> Chronic absence/school refusal	<input type="checkbox"/> Head injury/concussion	<input type="checkbox"/> Depressed mood/withdrawn
<b>Stresses/Trauma</b>	<input type="checkbox"/> Frequent stomachaches	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Family issues/conflict	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Witness to domestic violence	<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Ritualistic/Repetitive behaviors
<input type="checkbox"/> Multiple moves	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Irritability
<input type="checkbox"/> Deaths or losses	<input type="checkbox"/> Self-injurious behavior	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Chronic illness in family	<input type="checkbox"/> Chronic illness	<input type="checkbox"/> Disturbing thoughts
<input type="checkbox"/> History of sexual abuse	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Feelings of hopelessness
<input type="checkbox"/> History of physical abuse	<input type="checkbox"/> Sensory over/undersensitivity	<input type="checkbox"/> Extreme fears
<input type="checkbox"/> History of emotional abuse		<input type="checkbox"/> Running away
<input type="checkbox"/> History of neglect		<input type="checkbox"/> Suicidal thoughts/attempts
<input type="checkbox"/> Legal issues		<input type="checkbox"/> Drug/alcohol use

*Thank you for providing this information.*

Additional comments/personal or family history: