Jessica Schild, MSW, LCSW
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INTAKE PACKET: ADULTS

Name:____DOB:__________

Address:_______________________________City:______________State:_________Zip:_____

Home Phone:___________________Cell Phone:______________________________

Relationship Status: Single Married Partnered Separated Divorced Widowed

Number of Marriages: ____ Number of Biological Children____
Number of Step-Children:_____

Emergency Contact:__________________________
Relationship:_________________________________Phone:_________________________

Please list all members living in your home: Please use the back of form if not enough space.

Name	Age	Gender	Relationship	Relationship Quality

It is okay for the therapist to email or text to the phone number above to confirm appointments? Yes No

Is it okay to leave brief messages on the phone numbers listed above? Yes No

Have you received counseling services before? Yes No

If so, when, for what, and for how long?
____
____

Briefly describe the outcome of the prior counseling services:
____
____
____

Have you ever been prescribed psychotropic medication in the past? Yes No

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What was/is the name of the medication(s)? ______________________________________

Have you ever been told you have a mental health diagnosis? Yes No

If yes, what was the diagnosis?____

Please check if any family history of:

___Anxiety
___Depression
___Bipolar Disorder
___Schizophrenia
___Suicide Attempts
___Alcoholism
___Drug Abuse/Dependency
___Neglect
___Sexual abuse
___Physical Abuse
___Emotional Abuse

___Eating Disorders
___Chronic illness
___Panic Attacks
___Learning Disorders (dyslexia, math disability)
___Communication Disorders
___ADHD
___Violent Temper ("anger issues")
___Hallucinations/Delusions

Please explain any checked answers above and specify if it is on the maternal or paternal side:
____
____
____

Have you experienced any of the following, currently, or in the past?

_____Neglect
_____Physical, sexual or emotional abuse
_____CPS involvement
_____Trauma or assault
_____Violence in the home
_____Arrests or incarcerations

_____Alcohol or drug abuse
_____Serious physical illness
_____Loss of a long-term relationship
_____Employment Issues
_____Problems with sex

Please elaborate on checked items above:
____
____
____

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MEDICAL HISTORY:

Primary Care Physician:____
Address:_____________________________________Phone:________________________________
Please describe any past or current medical or physical concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc):
____
____
____
____
Please list any allergies:____
Please describe any surgeries or hospitalizations:
____
____
____
Please list any medications that you are currently prescribed:
____
____
____
____
Do you have any adverse side effects/reactions to the medications? Yes No
If yes, please describe:____
____

SOCIAL HISTORY:

How would you rate your physical health currently?

____Poor ____Fair ____ Good ____Excellent

Are you having any problems with your sleep habits? Yes No

If yes, please check where applicable:
____Sleeping too little _____Sleeping too much _____Poor quality sleep ____Disturbing dreams ____Other (please describe)____

Approximately how many times per week do you exercise?______
What types of exercise do you participate in?____

Are you having trouble with your appetite or eating habits? Yes No
If yes, plese check where applicable:
____Eating Less ____Eating More ____Binging ____Restricting

Have you experienced a significant weight loss or weight gain in the past 2 months?
Yes No

Do you consume alcohol? Yes No
If yes, please describe usage:____
Do you take recreational drugs or misuse prescription drugs? Yes No
If yes, please list:____
How often do you engage in recreational drug use or misuse prescription drugs?
____Daily ____Weekly _____Monthly _____Rarely

Have you had suicidal thoughts recently?
____Frequently ____Sometimes ____Rarely _____Never
Have you had suicidal thoughts in the past?
____Frequently ____Sometimes ____Rarely _____Never

Are you currently employed? Yes No
If yes, who is your current employer/position?_______________________________
Are you happy in your position? Yes No Sort of
Please list any work related stressors:_______________________________

Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship? __________________
On a scale of 1-10, how would you rate the quality of your relationship?_______

In the last year, have you experienced any significant life changes or stressors?
Yes No
If yes, please describe:
____
____

Do you consider yourself to be spiritual or religious? Yes No
If yes, please describe your faith or belief:_______________________________

SUPPLEMENTAL QUESTIONS:

What are some your strengths?
____
____
____

What do you like most about yourself?
____
____

What areas would you like to see improvements?
____
____
____

What activities/hobbies do you enjoy?

____
____
____

What are your goals for therapy?

____
____

Please check off any items that describe your behavior/feelings within the past six months:

___Feeling hopeless or helpless
___Frequent crying
___Prefer to isolate/be alone
___Difficulty concentrating
___Lack of interest in previous hobbies/activities
___Changes in eating or sleep habits
___Low frustration tolerance, irritability
___Suicidal thoughts
___Suicidal attempts
___Homicidal thoughts
___Extreme anxiety
___Panic Attacks
___Phobias (e.g. specific fears)
___Dramatic mood swings
___Rapid speech or racing thoughts
___Excessive energy (without need for sleep)
___Extreme anger
___Verbally or physically aggressive towards others
___Unexplained memory lapses (“blackouts” unrelated to drug use or alcohol)
___Excessive weight gain or loss
___Excessive alcohol use
___Illegal drug use
___Hearing voices
___Seeing images that others don’t see
___Relationship problems
___Violence at home
___Violence at work
___Sexual Difficulties
___Learning difficulties
___Frequent body complaints
___Body image issues
___Repetitive thoughts (obsessions)
___Repetitive behaviors (e.g. frequent hand washing, checking)
___Self-harming behaviors
___Recent move, new job, loss of friends/family
___Questions about gender
___Questions about orientation

If you would like, please expand upon any of the checked items or add other behaviors/traits not listed:

____
____
____