Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 E, I-30 Suite 100; Greenville, TX 75401
Phone: 903-274-4140 Fax: 877-310-9115

ADULT INTAKE FORM

Client's name: _____________________________ Date: ______________

Gender: ____F ____M Date of birth: _______ Age: ____ SSN: ________________

Form completed by ____

If you need more space for the following questions, please use the back of the sheet.
Primary reason(s) for seeking services:

____ Anger management ____ Anxiety ____ Coping ____ Depression

____ Addictive behaviors ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

____ Sleeping problems ____ Eating disorder____ Alcohol/drugs ____ Hyperactivity

____ Other mental health concerns (specify): ____

Is there a lawsuit or custody suit pending, or is there a probability of a lawsuit being filed regarding the problem for which you are seeking counseling? Yes ____ No ____
If yes, please explain: ____

EMOTIONAL/PSYCHIATRIC TREATMENT HISTORY

Information about (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric:	___	___	_____________	_____________	_____________
Treatment:	___	___	_____________	_____________	_____________
Suicidal thoughts/attempts:	___	___	_____________	_____________	_____________
Drug/alcohol treatment:	___	___	_____________	_____________	_____________
Hospitalization:	___	___	_____________	_____________	_____________

Diagnosis _______________________Treatment Beneficial? _____________________________

Has a family member had outpatient psychotherapy? Yes _________ No ___________
If yes, who/why (list all): ____

Current prescribed medications	Dose	Dates	Purpose	Side Effects
___________________________	_______	_______	___________	______________
___________________________	_______	_______	___________	______________

Current over-the-counter meds	Dose	Dates	Purpose	Side Effects
___________________________	_______	_______	___________	______________
___________________________	_______	_______	___________	______________

Has any family member used psychotropic/mental health medications? Yes_______ No ________
If yes, who/why (list all): ____

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Behavioral/Emotional
Please check any of the following that are typical for you:

____Affectionate
___Aggressive
___Alcohol Problems
___Angry
___Anxiety
___Blinking, Jerking
___Bizarre Behavior
___Careless, Reckless
___Chest Pains
___Clumsy
___Cooperative
___Confident
___Cyber Addiction
___Depression
___Destructive
___Difficulty Speaking
___Dizziness
___Drugs Dependence
___Eating Disorder
___Enthusiastic
___Excessive Masturbation
___Expects Failure
___Fatigue
___Fearful
___Frequent Injuries
___Frustrated Easily
___Gambling
___Generous
___Hallucinations
___Heart Problems
___Hopelessness
___Hurts Animals
___Irritable
___Impulsive
___Lazy
___Lies Frequently
___Listens to Reason
___Loner
___Low Self-Esteem
___Messy
___Moody
___Often Sick
___Over Active
___Over Weight
___Panic Attacks
___Phobias
___Poor Appetite
___Psychiatric Problems
___Sad
___Selfish
___Sexual Addiction
___Sick Often
___Short Attention Span
___Shy, Timid
___Sleeping Problems
___Slow Moving
___Speech Problems
___Suicidal Threats
___Suicidal Attempts
___Teeth Grinding
___Tics or Twitching
___Unsafe Behaviors
___Unusual Thinking
___Weight Loss
___Withdrawn
___Worries Excessively
Other:_______________

Please describe any of the above (or other) concerns: ______________________________

Medical/Physical Health (check all that apply to your health)_

___Abortion
___ Anemia
___Asthma
___Blackouts
___Blindness
___Bronchitis
___Cerebral Palsy
___Chicken Pox
___Congenital Problems
___Croup
___Cancer
___Deafness
___Diabetes
___Diphtheria
___Dizziness
___Ear Aches
___Ear Infections
___Eczema
___Encephalitis
___Fevers
___Glandular Problems
___Heart Diseases
___High Blood Pressure
___Kidney Disease
___Mental Illness
___Migraines
___ Multiple Sclerosis
___Mental Retardation
___Muscular Dystrophy
___Nervousness
___Perceptual Motor Disorder
___Seizures
___Spinal Bifida
___ Suicide

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List any current health concerns:____
____

List any recent health or physical changes:_______________________________________
____

List any known allergies: ____
____

Describe any serious hospitalizations or accidents:

Date	Age	Reason
______	_______	____
______	_______	____
______	_______	____

Nutrition (Define your current nutritional status)
Do you eat Breakfast, Lunch, Dinner, Snacks? Yes_____ No _________

Would you consider your food choices healthy? Yes ______ No __________

Do you have any issues relating to nutrition? Yes ____________ No _________

Please explain: ____
____

Most Recent Examinations (Define any concerns, problems, issues)

Type of Examination	Date of Most Recent Visit	Results
Physical Examination:	______________________	_______________________
Dental Examination:	______________________	_______________________
Vision Examination:	______________________	_______________________
Hearing Examination:	______________________	_______________________

CHILDHOOD (Check corresponding boxes defining your childhood experience)
Present entire childhood: Mother ____ Father____ Stepmother ______ Stepfather ______

Brother(s) _______ Sister(s) _________ Other (specify)_______________________

Present part of childhood: Mother ____ Father____ Stepmother ______ Stepfather ______

Brother(s) _______ Sister(s) _________ Other (specify)_______________________

Not present at all: Mother ____ Father____ Stepmother ______ Stepfather ______

Brother(s) _______ Sister(s) _________ Other (specify)_______________________

CLIENTS PARENTS HISTORY

Parent's marital status: Married to each other for ____years;
Separated for ____ years Divorced for ____ years; Please Explain: ______________________

Describe parents:
Father deceased for ____ years, age of client at father's death
Father Occupation_____________________________
Education Level___________________________
General Health____________________________
Father remarried ____ times Father involved with someone else _______
Your relationship with parent __Poor __Average __Good; Please Explain: __________________

Mother deceased for ____ years, age of client at mother's death
Mother Occupation______________________
Education Level___________________________
General Health____________________________
Mother remarried ____ times; Mother involved with someone else______
Your relationship with parent __Poor __Average __Good; Please Explain: __________________

Describe childhood family experience:

____Outstanding Home Environment _____ Normal Home Environment

____Chaotic Home Environment _____Witnessed physical/verbal/sexual abuse toward others

____Witnessed physical/verbal/sexual abuse from others

Age of emancipation from home:_______Circumstances:_____________________________

Special circumstances in Childhood:____

IMMEDIATE FAMILY/ RELATIONSHIPS (*Describe your family situation and living arrangements)* ____

Your Current Relationship Status: Never been in serious relationship____

Not currently in relationship ____ Currently in serious relationship____

Martial Status:____ Single, never married; Engaged ____ months

Married for ____ years; Divorced for ____ years; Separated for ____ years

Divorce in process ____ months; Live-in for ____ years; Prior marriages self ____ partner____

Relationship Satisfaction: Very satisfied with relationship ____ Satisfied____

Somewhat satisfied ___ Somewhat dissatisfied ___ Dissatisfied ___ Very dissatisfied ____

Describe any past or current significant issues in intimate relationships: __________________

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IMMEDIATE FAMILY CONTINUED
List all persons/family members living in client's household:

Name **Family member**	Age	Gender	Relationship (e.g., grandparent, cousin, foster child)	Quality of Relationship with the Client
________________	____	__F __M	______________	__Poor __Average __Good
________________	____	__F __M	______________	__Poor __Average __Good
________________	____	__F __M	______________	__Poor __Average __Good
________________	____	__F __M	______________	__Poor __Average __Good
Others living in the household			Relationship (e.g., grandparent, cousin, foster child)	
________________	____	__F __M	______________	__Poor __Average __Good
________________	____	__F __M	______________	__Poor __Average __Good
________________	____	__F __M	______________	__Poor __Average __Good
________________	____	__F __M	______________	__Poor __Average __Good
Children not listed above				
________________	____	__F __M	______________	__Poor __Average __Good
________________	____	__F __M	______________	__Poor __Average __Good

Describe any past or current significant issues in other immediate family relationships:________

____

Comments: ____

____

____

FAMILY MEDICAL HISTORY (Check all that apply for client)
Is there a history of any of the following in the family:

___Tuberculosis
___Thyroid Problems
___Alcoholism
___Birth Defects
___Cancer
____Drug Abuse
___Emotional Problems
___Mental Retardation
____Alzheimer's Disease/Dementia
___Diabetes
___Heart Disease
Other: ______________
___Behavior Problems
___Stroke

SUBSTANCE USE HISTORY (Check all that apply for client)

Family alcohol/drug abuse history: ___ Father ____Mother ____Grandparent(s) -

____Sibling(s) ____Stepparent/live-in ____ Uncle(s)/Aunt(s) ____ Spouse/Significant Other

____Children ____Other __________ Describe: ___________________________________

Client's Substance use status: ____No history of abuse ____Active abuse

____Early full remission ____Early partial remission ____Sustained full remission

____Sustained partial remission

Clients Treatment history: Outpatient (ages[s] _________) Inpatient (age[s] ____________)

12-step program (age[s] _____________) Stopped on own (age[s] _____________)

Describe ____

Consequences of substance use (check all that apply):

___Hangovers

___Seizures

___Blackouts

___Overdose

___Binges

___Withdrawal symptoms

___Medication complications

___Tolerance changes

___ Loss of control amount used

___Sleep disturbance

___Assaults

___Suicidal impulse

___Relationship conflicts

___Job loss

___Arrest

Other:____________

Substances used (list all):____

____

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SOCIO-ECONOMIC HISTORY (Check all that apply)

Living Situation:

____ Housing adequate ____Homeless _____Housing crowded

____Dependent on others for housing ____Housing dangerous/deteriorating

____ Living companions dysfunctional

Employment: Where employed______________________________

____Employed and satisfied ____ Employed but dissatisfied ____ Unemployed

____Coworker conflicts ____Supervisor conflict ____Unstable work history

____Disabled (describe)____________________

Feelings about Work:

___Anxious ___Passive ___Enthusiastic ___Fearful

___Eager ___No Expression ___Bored ___Rebellious

___Other (describe):____

Financial Situation:

_____No current financial problems_____ Large indebtedness

_____Poverty or below-poverty income_______ Impulsive spending

_____Relationship conflicts over finances _______Other(Describe)___________________

Social Support System:

_____Supportive network ____ Few friends____ Substance-use-based-friends

_____No friends _____Distant from family of origin

Military History:

____Never in military ____Served in military-no incident ____Served in military with incident

Describe_______________________

Legal History:

_____No legal problems ____Now on parole/probation ____Arrest(s) not substance-related

____Arrest(s) substance-related ____ Court ordered this treatment

Jail/prison ____ times, total time served: ____

Describe last legal difficulty: ____

____

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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)

Activity	How often now? weekly, none, ect)	How often in the past? (weekly, none, ect)
____________________	______________________	____________________
____________________	______________________	____________________
____________________	______________________	____________________
____________________	______________________	____________________
____________________	______________________	____________________
____________________	______________________	____________________

Any additional information that you believe would assist us in understanding your situation?

____

____

____

Any additional information that would assist us in understanding current concerns or problems?

____

____

____

____

What are your goals for therapy? ____

____

What family involvement would you like to see in the therapy? ___________________

____

Are you currently suicidal at this time? ___Yes ___No

If Yes, explain: ____

____

____