PCHC
PANHANDLE COUNSELING & HEALTH CENTER
Health Clinic

Adult Intake Form

Name: _____ **Date:** _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:

_____

_____

What are the goals and objectives that you want from your treatment?

_____

Please check all of the behaviors and symptoms that you consider problematic:

	Distractibility		Change in appetite		Suspicion/paranoia
	Hyperactivity		Lack of Motivation		Racing Thoughts
	Impulsivity		Withdrawal from people		Excessive Energy
	Boredom		Anxiety/worry		Wide mood swings
	Poor memory/confusion		Panic attacks		Sleep problems
	Seasonal mood changes		Fear away from home		Nightmares
	Sadness/depression		Social discomfort		Eating problems
	Loss of pleasure/interest		Obsessive thoughts		Gambling problems
	Hopelessness		Compulsive behavior		Computer addiction
	Thoughts of death		Aggression/fights		Problems with pornography
	Self-harm behaviors		Frequent arguments		Parenting problems
	Crying spells		Irritability/anger		Sexual problems
	Loneliness		Homicidal thoughts		Relationship problems
	Low self-worth		Flashbacks		Work/school problems
	Guilt/shame		Hearing voices		Alcohol/drug use
	Fatigue		Visual hallucinations		Recurring, disturbing memories
	Other: _____				

Strengths, Needs, Abilities, Preferences & Liabilities

Please describe your perceptions concerning your personal strengths, needs, abilities & preferences as you relate them to your overall functioning in the community. Include any liabilities in these areas that need to be addressed in your treatment, as well as preferences for treatment.

Strengths: _____
Needs: _____
Abilities: _____
Preferences: _____
Liabilities: _____

Leisure or Community Activities and Personal Interests

Are you involved in recreational, leisure, or community activities? ○ **Yes** ○ **No**

If yes, please describe these and any other personal interests:

_____
_____
_____
_____

Are your problems affecting any of the following?

	Handling everyday tasks		Self-Esteem		Relationships		Hygiene
	Work/School		Housing		Legal matters		Finances
	Recreational Activities		Sexual Activity		Health		

Have you ever had thoughts, made statements, or attempted to hurt yourself?

- No
- Yes: Please Describe: _____

Have you ever had thoughts, made statements, or attempted to hurt someone else?

- No
- Yes: Please Describe: _____

Have you recently been physically hurt or threatened by someone else?

- No
- Yes: Please Describe: _____

FAMILY AND DEVELOPMENT HISTORY

Relationship:	**Name:**	**Age:**	**Quality of Relationship**	**Good, Fair or Poor**
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Spouse/partner				
Children				

Family and Development History

Family Mental Health Problems	Who
Hyperactivity	
Sexually abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive compulsive	
Anger-Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

Are you involved in a relationship with a significant other? ○ **Yes** ○ **No**
How do you perceive the quality of your relationship with your significant other? _____
_____
Who are your supports? _____
_____

	Parents legally married or living together		Mother remarried:	Number of times:_____
	Parents temporarily separated		Father remarried:	Number of times:_____
	Parents divorced or permanently separated			

Please check if you have experienced any of the following types of trauma or loss:

	Emotional abuse		Neglect		Lived in a foster home
	Sexual abuse		Violence in the home		Multiple family homes
	Physical abuse		Crime victim		Homelessness
	Parent substance abuse		Parent illness		Loss of a loved one
	Teen pregnancy		Placed a child for adoption		Financial problems
	Changes in weather affecting mental health		Other:		

Have you ever experienced or witnessed a traumatic event? ○ **Yes** ○ **No**
If yes, please indicate if the traumatic event was **experienced** or **witnessed** and what was the date of trauma:_____
_____
Did you receive services to address trauma issues? ○ **Yes** ○ **No**
If yes, when and where: _____
Have you experienced any domestic violence or has there been violence toward others in the family?
○ **Yes** ○ **No** If yes, is the abuse current? ○ **Yes** ○ **No**

If you answered yes to any of the above, please describe: _____
_____

Did you receive services to address domestic violence issues? ○ **Yes** ○ **No**
If yes, when and where _____
Are you a victim of emotional or psychological abuse or neglect? ○ **Yes** ○ **No**
If so, please describe: _____
_____

Did you receive services to address emotional or psychological abuse or neglect issues? ○ **Yes** ○ **No**
If yes, when and where_____
Are you a victim of sexual abuse? ○ **Yes** ○ **No**
If yes, please describe the type of abuse, if reported and if so, to whom and the date of the abuse:_____
_____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When	Provider/Program	Reason for Treatment	
		Outpatient Counseling				
		Medication (Mental Health)				
		Psychiatric Hospitalization				
		Drug/Alcohol Treatment				

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)					Past Use				
	Y	N	Frequency	Amount	Method of Use	Y	N	Frequency	Amount	Age 1st Use
Tobacco										
Caffeine										
Alcohol										
Marijuana										
Cocaine/crack										
Ecstasy										
Heroin										
Inhalants										
Methamphetamines										
Pain Killers										
PCP/LSD										
Steroids										
Tranquilizers										

Have you had withdrawal symptoms when trying to stop using any substances?

- o No
- o Yes: Please Describe: _____

Have you had problems with work, relationships, health, the law, etc…due to your substances use?

- o No
- o Yes: Please Describe: _____

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

	Allergies		Asthma		Headaches		Stomach aches
	Chronic pain		Surgery		Serious accident		Head injury
	Dizziness/fainting		Meningitis		Seizures		Vision problems
	High fevers		Diabetes		Hearing problems		Miscarriage
	Sexually transmitted disease		Abortion		Sleep disorder		Other:

Please list any **CURRENT** health concerns: _____.

Current prescription medications:

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, supplements, herbal remedies, etc…)

_____

_____

Allergies and/or adverse reactions to medication:

_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

	Family		**Community Group**		**Students**
	Friends		**Neighbors**		**Co-Workers**
	Support/ Self-Help Group		**Religious Group**		**Other:**

To Which cultural or ethnic group do you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe:

_____

_____

How important are spiritual matters to you?

○ Not at all ○Little○Somewhat ○Very much

Spiritual Beliefs

Religious Affiliations: _____ ○ None

Are you or your family active in spiritual religious activities? ○Yes ○ No

If yes, please describe:

_____

_____

_____

MISCELLANEOUS INFORMATION

Employment

Employer: _____ Position: _____

Length of time in this position: _____ Job Duties: _____

Stress level of this position: Low: _____ Medium: _____ High: _____

Education

Are you currently attending school? ○ Yes ○ No Last Grade Completed: _____

	High School Graduate OR		GED	Year:
	Associate's Degree	Year:		Area of Study
	Undergraduate Degree	Year:		Area of Study
	Graduate Degree	Year:		Area of Study

Reading Ability? ○ Poor ○ Fair ○ Average ○ Above Average ○ Excellent

Military Service

Have you been/are you currently in the military? (If no, skip remainder of this section)

- Branch: _____
- Date of Discharge: _____
- Type of Discharge: _____
- Were you in Combat: _____

Additional information you feel is important to your care.

_____

_____

Legal

Have you ever been convicted of a misdemeanor, criminal arrests/convictions, felonies and other juvenile/criminal justice system involvement?

○ Yes ○ No

Please explain

_____

_____

☐ **DHS Case** ☐ **OJA Case** ☐ **JB-Probation** ☐ **Parental** ☐ **Other: _____**

Case Worker Name: _____ Phone #: _____

Lawyers Name: _____Phone#: _____

Are you currently involved in any divorce or child custody proceedings?

○ Yes ○ No

Please explain

_____

_____

☐ **DHS Case** ☐ **OJA Case** ☐ **JB-Probation** ☐ **Parental** ☐ **Other: _____**

Case Worker Name: _____ Phone #: _____

Lawyers Name: _____Phone#: _____