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CONFIDENTIAL ADULT INTAKE

PERSONAL INFORMATION:
My name is:_____ Date:_____
Address:_____
City:_____
Zip Code:_____
Home Phone: _____ May we call? Y/N Leave messages? Y/N
Cell Phone: _____ May we call? Y/N Leave messages? Y/N
Email:_____
Date of birth: _____ Age: _____
I currently live with:_____
Relationship(s) to me:_____
I am here because:_____
My strengths are:_____
My interests are/ I enjoy:_____
Gender: male female mtf ftm queer other:_____
My sexual orientation is: Heterosexual Bisexual Gay Lesbian Queer other:_____
Emergency Contact:_____ Phone: _____
Relationship to Emergency Contact Person:_____
How did you hear about Orion Psychotherapy?_____

INSURANCE:
Insurance Provider: _____

Individual Number: _____

Type of Insurance (if known): _____
Co-Pay: _____
Deductible: _____

As far as you know have you met any of the deductible:_____

Credit Card on File (this will be secured with other documents in a locked drawer and used for missed sessions):

Type of card:_____ Card #_____

Name and Zip code of card:_____ _____

Expiration and Code on Back:_____ _____

MENTAL HEALTH HISTORY:
Previous therapy counseling (when with whom):_____
Any mental health issues (list and describe, previous diagnoses, including any course of treatment):_____
Psychotropic Medications currently used (name, dosage, length of time taking it, side effects experienced):
_____

_____
Psychotropic Medications previously used (name, dosage, length of time taking it, side effects experienced): _____

_____

Current Psychiatrist (name, address, #):_____

VOCATION (fill out for parents for under 18):
I am employed: Yes No
My title is:_____ I am employed with:_____
I have worked there for: _____

Salary per year/month:_____
My job has been impacted by my presenting concerns: Yes No
If Yes, please explain:_____

EDUCATION:
I completed: grade school highschool BA Masters graduate school
My experience of school was: _____

ABUSE HISTORY: (I understand that this can be a sensitive section, feel free if you prefer to leave some of it blank and we can discuss in person)
I have been physically abused: Yes No
If Yes, please explain:_____
I have been emotionally abused: Yes No
If Yes, please explain:_____
I have been sexually abused: Yes No
If Yes, please explain:_____
My presenting concerns are impacted by the above abuse: Yes No
If Yes, please explain:_____
I feel I have been exploited: Yes No
If Yes, please explain:_____

MILITARY HISTORY:
I served in the military:
Which branch?_____
If Yes, when:_____
Type of discharge?_____
My presenting concerns were impacted by my military service: Yes No
If Yes, please explain:_____

LEGALHISTORY:
I have been involved with the legal system: Yes No
If Yes, please explain:_____

CULTURAL/RELIGIOUS HISTORY:
My ethnic or cultural background has been an important factor in my life: Yes No
If Yes, please explain:_____
I have cultural concerns/practices that need to be considered by my therapist: Yes No
If Yes, please explain:_____
I am a spiritual person: Yes No
The source of my spirituality is:_____
I am connected with a religious organization/spiritual group: Yes No
If Yes, please name:_____
I am involved: Actively Occasionally Minimally Not at all
This is a support system for me: Yes No
If Yes, please explain:_____

PRESENTING CONCERNS:
Are you experiencing any symptoms that have been a concern for more than four weeks and get in the way of you living life? ☐ Yes ☐ No
If Yes, please list which symptoms:_____
☐ Low energy
☐ Low self-esteem ☐ Poor concentration
☐ Thoughts of suicide ☐ Hopelessness
☐ Loneliness ☐ Worthlessness
☐ Depressed ☐ Isolation/social withdrawal

- [ ] Sadness/loss
- [ ] Guilt
- [ ] Sleep disturbance
- [ ] Stress
- [ ] Anxiety/panic
- [ ] Chest pain
- [ ] Chills/hot flashes
- [ ] Fear of dying
- [ ] Nausea
- [ ] Racing thoughts
- [ ] Headaches
- [ ] Bowel disturbances
- [ ] Feel tense
- [ ] Can't make friends
- [ ] Financial problems
- [ ] Dizziness
- [ ] Fatigue/exhaustion
- [ ] Feel panicky
- [ ] Thoughts of hurting yourself
- [ ] Don't like weekends and vacations
- [ ] Appetite disturbance
- [ ] Thoughts of hurting someone else
- [ ] Heart pounding/racing
- [ ] Trembling/shaking
- [ ] Tingling/numbness
- [ ] Fear of going crazy
- [ ] Phobias
- [ ] Obsessions/compulsive behaviors
- [ ] Palpitations
- [ ] Nightmares
- [ ] Unable to relax
- [ ] Can't keep a job
- [ ] Excessive sweating
- [ ] Stomach trouble
- [ ] Take sedatives
- [ ] Conflict

Check all that apply to you:

- [ ] Sexual problems
- [ ] Overambitious
- [ ] Memory problems
- [ ] Reproductive concerns
- [ ] Insomnia
- [ ] Tremors
- [ ] Allergies
- [ ] Home conditions bad
- [ ] Concentration difficulties
- [ ] Work problems
- [ ] Excessive drinking
- [ ] Can't hold onto an idea
- [ ] Lose track of time
- [ ] Anger/frustration
- [ ] Easily agitated/annoyed
- [ ] Spousal abuse concerns
- [ ] Inferiority feelings
- [ ] Fainting spells
- [ ] Alcoholism
- [ ] Shy with people
- [ ] Unable to have a good time
- [ ] Can't make decisions
- [ ] Easily startled
- [ ] Self criticism
- [ ] Not thinking clearly/confusion
- [ ] Delusions/hallucinations
- [ ] Feeling that you are not real
- [ ] Feeling that things around you are not real
- [ ] Unpleasant thoughts that won't go away
- [ ] Defying rules
- [ ] Blaming others
- [ ] Excessive use of drugs
- [ ] Excessive use of prescription medications
- [ ] Blackouts
- [ ] Avoiding others
- [ ] Crying spells
- [ ] Paranoia/distrust
- [ ] Eating concerns (binging, purging, restricting)
- [ ] Mood fluctuations
- [ ] Feel out of control
- [ ] Self injury
- [ ] Excessive behaviors (spending, gambling)
- [ ] Other:_____

Three Goals for therapy (leave for us to do in session):

1

2.

3.