Adult Intake Form

Ready for the World, LLC Today's Date _____

PERSONAL INFORMATION

CLIENT NAME _____ AGE _____ DATE OF BIRTH _____ GENDER _____

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Address _____ City, State _____ Zip _____

Home phone _____ Cell Phone _____ Work Phone _____

Please indicate with an * which phone numbers we may NOT leave a message.

Email address: _____

Please review our Informed Consent, Information and Policies regarding use of email correspondence.

RESPONSIBLE PARTY _____ Responsible Party's SSN _____

(If client is a minor, the responsible party is the parent or guardian bringing the minor for treatment and signing this form).

If different from client:

Address _____ City, State _____ Zip _____

Home phone _____ Cell Phone _____ Work Phone _____

Person to contact in case of emergency _____

Name Phone # Relationship

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Policy Holder's Name _____	Policy Holder's Name _____
Policy Holder's Date of Birth _____	Policy Holder's Date of Birth _____
Relationship to Client _____	Relationship to Client _____
Home address (if different) _____	Home address (if different) _____
_____	_____
Insurance Company Name _____	Insurance Company Name _____
Policy Holder's ID # _____	Policy Holder's ID # _____
Group # _____	Group # _____
Employer Name _____	Employer Name _____

REFERRAL INFORMATION

How did you hear about Ready for the World/Maureen? (Please specify)

Family Member/Friend _____ Internet/Web Search _____

Therapist _____ School _____

Physician _____ Other _____

Presenting Problem/Reason for Treatment

What is the primary reason you are seeking help? _____

_____

_____

Current Concerns

Please check all of the symptoms below that apply to you:

☐ Loss of interest/not enjoying things	☐ Easily distracted	☐ Excessive anxiety or worry
☐ Guilt	☐ Reckless behavior/taking excessive risks	☐ Experiencing panic attacks
☐ Decreased energy	☐ Feeling overly important	☐ Avoiding going places
☐ Difficulty concentrating	☐ Racing thoughts	☐ Avoiding being with others
☐ Loss of appetite	☐ Talkative	☐ Checking things repeatedly
☐ Sleep difficulties	☐ Little need for sleep	☐ Need things to be perfect
☐ Thoughts of suicide	☐ Very active/on the go all the time	☐ Overly fearful
☐ Self-harm	☐ Impulsive behavior	☐ Sensitive to criticism
☐ Depression	☐ Trouble managing pain	☐ Concerns with alcohol use
☐ Feeling helpless/hopeless	☐ Stomachaches/digestion issues	☐ Concerns with drug use
☐ Excessive crying	☐ Headaches	☐ Gambling
☐ Moody	☐ Eating difficulties	☐ Spending issues
☐ Feeling empty inside/apathetic	☐ Body image difficulties	☐ Hoarding
☐ Afraid of being judged or rejected	☐ Sexual difficulties	☐ Excessive use of video games or technology
☐ Angry/easily irritated	☐ Untreated health problems	☐ Sexual or pornography addiction
☐ Feelings of being worthless	☐ Problems caring for family member	
☐ Difficulty remembering	☐ Feeling suspicious at times	☐ Financial problems
☐ Confusion	☐ Having strange experiences	☐ Learning problems
☐ Getting lost or forgetting things more often	☐ Hearing voices	☐ Relationship problems
☐ Difficulty making decisions	☐ Seeing things	☐ Legal problems
☐ Feeling overwhelmed	☐ Feeling unsafe	☐ Work problems
☐ Difficulty controlling temper	☐ Feeling trapped in a relationship	☐ Stealing/lying
☐ Trouble handling change	☐ Feeling Bullied or picked on	☐ Abusive toward others
	☐ History of traumatic experiences	☐ Thoughts of hurting others

Please describe any issues not listed above. _____

_____

_____

How do these concerns impact your daily life? _____

_____

_____

What do you consider to be your strengths? _____

What do you consider to be your weaknesses? _____

Family Information

Sexual Orientation

☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Unsure

Family & Supportive Relationships

Marital Status (check all that apply):

☐ Married ☐ Never married ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Widowed

Name	Age	Relationship to Client (spouse, domestic partner,	Quality of Relationship	Occupation
			☐ Good ☐ Fair ☐ Poor	
			☐ Good ☐ Fair ☐ Poor	
			☐ Good ☐ Fair ☐ Poor	
			☐ Good ☐ Fair ☐ Poor	
			☐ Good ☐ Fair ☐ Poor	
			☐ Good ☐ Fair ☐ Poor	
			☐ Good ☐ Fair ☐ Poor	

Medical Information

Have you ever received inpatient or outpatient mental health services? ☐ Yes ☐ No

Where (Include name of therapist)?	When?	Was this helpful?
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Primary Care Physician (Name/Practice): _____

Address _____ Phone _____

List any current health concerns _____

Please list all current medications you are prescribed (attach another page if needed):

Name of Medication	Dosage/Amount/Frequency	Prescriber	Reason

Substance Use

Do you drink alcohol?	☐ Daily use	☐ Occasional Use	☐ None
Do you use tobacco?	☐ Daily use	☐ Occasional Use	☐ None
Do you use marijuana?	☐ Daily use	☐ Occasional Use	☐ None
Do you use drugs?	☐ Daily use	☐ Occasional Use	☐ None

Has alcohol/drug use interfered with family, work, health or interpersonal life? ☐ Yes ☐ No

If yes, please explain: _____

Have others viewed your use as a problem? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any substance abuse treatment? ☐ Yes ☐ No

If yes, please explain: _____

Legal History

Are you involved with the legal system, Friend of the Court or Child Protective Services? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently on probation or parole? ☐ Yes ☐ No

Have you been involved with the legal system in the past? ☐ Yes ☐ No

Education/Employment Information

Highest (or current) Grade Level Achieved: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Stay-at-home parent

☐ Retired ☐ Student ☐ Volunteer/Internship

Current Employer:_____ How long? _____

Please describe any issues with your current employment situation you would like to address in therapy:

_____

_____

Trauma History

Have you had a history of trauma, abuse or neglect? ☐ Yes ☐ No

If yes, what type of abuse or trauma occurred? ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect

☐ Verbal ☐ Other : _____

_____

Treatment Goals

What are areas you would like to address in therapy?

- ☐ Improve coping strategies
- ☐ Issues with spouse/significant other
- ☐ Issues with parent(s)
- ☐ Issues with child(ren)
- ☐ Become more organized
- ☐ Decrease anxiety
- ☐ Decrease depression
- ☐ Feel better about myself
- ☐ Deal with loss
- ☐ Job/career dissatisfaction
- ☐ Take better care of myself
- ☐ Substance use/abuse
- ☐ Weight management
- ☐ Improve social skills
- ☐ Deal with past trauma
- ☐ Hoarding
- ☐ Sexual issues
- ☐ Financial concerns
- ☐ Sexual orientation
- ☐ Eliminate abuse toward others
- ☐ Pursue divorce
- ☐ Eliminate self-injury
- ☐ Improve quality of life
- ☐ Deal with infidelity
- ☐ Spouse/SO's addiction
- ☐ Deal with divorce/end of relationship

Please briefly describe issues checked above and any other issues you may want to address: _____

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