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| **ADULT PSYCHOLOGICAL INTAKE EVALUATION** |

**To the Patient:** Your responses to the following questions will help your psychologist better understand you and your situation. This will facilitate the best possible treatment. Please answer all questions as completely as possible.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B.\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Age:\_\_\_\_\_\_Sex: \_\_\_\_ F \_\_\_\_ M

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you/how did you find us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you feel your psychologist should be aware of any special treatment consideration due to gender, age, disability, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENTING PROBLEM**

Check here if you are experiencing any of the following problems:

\_\_\_ Pain \_\_\_ Drug/Alcohol Abuse \_\_\_ Eating/Appetite \_\_\_ Marital/Relationship

\_\_\_ Depression \_\_\_ Attention/Concentration \_\_\_ Ill Health \_\_\_ Family

\_\_\_ Unstable Mood \_\_\_ Stress Management \_\_\_ Sexual \_\_\_ Employment

\_\_\_ Suicidal Thoughts \_\_\_ Anxiety/Worry \_\_\_ Financial \_\_\_ Legal

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How has it changed over time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PSYCHOLOGICAL HISTORY**

Have you ever taken medication for anxiety for anxiety, depression, sleep, or other emotional conditions: \_\_\_\_Y \_\_\_\_\_N

If YES, what and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been in counseling or psychotherapy before? \_\_\_\_\_Y \_\_\_\_\_N

If YES, when, and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any past hospitalizations for emotional problems? \_\_\_\_\_Y \_\_\_\_\_N

If YES, when, and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever intentionally hurt yourself or made a suicide attempt? \_\_\_\_\_Y \_\_\_\_\_N

If YES, please explain how and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL HISTORY**

Check if you are currently experiencing or have ever experienced the following medical issues:

\_\_Chronic Pain \_\_ Anemia \_\_ Allergies

\_\_Heart (trouble, disease, surgery) \_\_ Thyroid problem \_\_ Sinus problems

\_\_Chest pain or angina pectoris \_\_ Kidney or bladder problems \_\_ Weight change

\_\_Abnormal blood pressure \_\_ Liver Disease \_\_ Eating problems

\_\_ Fainting Spells \_\_ Hepatitis- type A B C \_\_ Ulcers/Abdominal pain

\_\_ Epilepsy (Seizure Disorder) \_\_ Jaundice/rashes/sores \_\_ Venereal disease

\_\_ Neurological disorders \_\_ Frequent or severe headaches \_\_ HIV positive/AIDS/ARC

\_\_ Memory Loss \_\_ Hemophilia blood disease \_\_ Broken Bones

\_\_ Stroke \_\_ Cancer/Tumors \_\_ Hearing problems

\_\_ Arthritis/Rheumatism \_\_ Emphysema \_\_ Vision problems

\_\_ Head Injury \_\_ Pregnancies not carried to term \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you checked any of the above medical items, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any allergies or reactions to medications? \_\_\_Y \_\_\_N

If YES, what medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any prescribed medications? \_\_\_Y\_\_\_N

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| Name of Medication | Dose and Frequency | Reason for Medication | Physician |
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Please indicate any homeopathic or alternative forms of medicine you are currently using: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or chew tobacco? \_\_\_\_Y\_\_\_\_N If so, how much per day or week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink? \_\_\_\_Y \_\_\_\_N if so, what do you drink and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY**

Please list Parents, Siblings, Spouse, Children and Significant Relatives/Others:

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| --- | --- | --- | --- | --- |
| Name (First, Last) | Relationship | Age | School/Occupation | City of Residence |
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Who raised you?

\_\_\_Both Parents \_\_\_Mother alone \_\_\_Mother w/significant other \_\_\_ Father alone \_\_Father w/ significant other \_\_\_Other

Current Relationship Status:

\_\_\_Single \_\_\_Long-term relationship \_\_\_Married \_\_\_Re-Married \_\_\_Divorced \_\_\_Separated \_\_\_Widowed

Who currently lives in your household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you having problems with your children? \_\_\_Y \_\_\_N

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever experienced any emotional, verbal, physical, or sexual abuse? \_\_\_\_Y \_\_\_\_N

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you concerned about alcohol or drug use of you or someone in your family? \_\_\_\_Y \_\_\_\_N

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you grow up in a home in which a parent abused alcohol or drugs? \_\_\_\_Y \_\_\_\_N

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How would you describe your parents’ marital relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please indicate if any family members have had the following and specify that person’s relationship to you.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Cancer | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Alcohol abuse | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Diabetes | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Drug abuse | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Epilepsy | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Behavior disorder | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Migraine headaches | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Emotional problems | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Physical handicap | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Mental illness | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Tuberculosis | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Intellectual disorder | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Huntington’s chorea | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Nervousness | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Muscular dystrophy | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Reading problems | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Sickle cell anemia | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Learning disability | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Tay-sachs disease | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Speech problem | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Tourette’s syndrome | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Language problem | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Cerebral palsy | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Severe head injury | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Birth defect | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Other | \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SOCIAL HISTORY**

How do you relate to others? Check all that apply:

\_\_\_ I seem to focus heavily on my interests \_\_\_ I am bothered by sounds, textures, smells that other people are not

\_\_\_ Have many close friends \_\_\_ Have several close friends \_\_\_ Have few close friends

\_\_\_ Have no close friends \_\_\_ Make friends easily \_\_\_ Am a leader

\_\_\_ Am a follower \_\_\_ Fight with others \_\_\_ Prefer to be alone

\_\_\_ Interact well with family members \_\_\_ Difficulty with siblings \_\_\_ Prefers younger friends

\_\_\_ Am teased by others \_\_\_ Feel rejected by peer group \_\_\_ Feel lonely often

\_\_\_ Have friends who get in trouble \_\_\_ Want friends, but don’t know how to make or keep them

\_\_\_ I have difficulty understanding jokes \_\_\_ I have difficulty understanding people’s feelings

\_\_\_ I stick to the same routine every day \_\_\_ I find change very stressful

If you’ve had trouble getting along with others, how long has this gone on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How many hours do you spend on electronics each day (i.e., phone, tablet, gaming console, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use electronics before bedtime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, how many hours/minutes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATIONAL AND VOCATIONAL HISTORY**

Highest grade completed? \_\_\_ GED completed? \_\_Y \_\_N How did you do academically in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you in any special education programming? \_\_Y \_\_N When/for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was your conduct throughout school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If attended college, what is your degree and /or status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of college: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently employed? \_\_\_ Y \_\_\_ N If NO, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a brief overview of your work history starting with you *most recent* job:

|  |  |  |
| --- | --- | --- |
| JOB TILTLE | EMPLOYER | LENGTH OF EMPLOYMENT |
|  |  |  |
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Have you ever been terminated from a job? \_\_\_Y \_\_\_N

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any language or reading difficulties? \_\_\_Y \_\_\_N

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MILITARY HISTORY**

Did you ever serve in the military? \_\_\_Y \_\_\_N Branch of military? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/Type of Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have combat history? \_\_\_\_Y \_\_\_\_ N

**LEGAL HISTORY**

Do you have a legal history consisting of past or current: (If YES to any of these, please explain)

Lawsuits \_\_\_ Y \_\_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Restraining Order \_\_\_ Y \_\_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Divorce/Custody \_\_\_ Y \_\_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arrests \_\_\_ Y \_\_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incarceration \_\_\_ Y \_\_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Probation \_\_\_ Y \_\_\_ N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CULTURAL/RELIGIOUS/SPIRITUAL HISTORY**

What is your ethnic or cultural heritage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what religious tradition did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current religion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How important do you consider your ethnicity or religious beliefs/traditions in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**GOALS**

What goals would you like to accomplish in treatment?

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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychologist/Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**ADULT SYMPTOM CHECKLIST**

Please read each symptom/behavior listed and indicate how often you have experienced it (frequency), and how long you have experienced it (duration).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptoms** | **Rarely** | **3-4 times**  **month** | **3-6 times**  **week** | **Daily** | **How**  **Long** |
| 1. Anxious, tense mood, difficulty controlling worry | **0** | **1** | **2** | **3** |  |
| 2. Panic attacks (intense and sudden fear) | **0** | **1** | **2** | **3** |  |
| 3. Anxiety and/or avoidance in social situations | **0** | **1** | **2** | **3** |  |
| 4. Specific intense fears (e.g. driving, needles, etc.)  *Specify:* | **0** | **1** | **2** | **3** |  |
| 5. Obsessions and/or compulsions (excessive concern with  cleanliness, orderliness, checking things, etc.). | **0** | **1** | **2** | **3** |  |
| 6. Having urges to break or smash things | **0** | **1** | **2** | **3** |  |
| 7. Difficulty concentrating and focusing on tasks | **0** | **1** | **2** | **3** |  |
| 8. Fatigue, feeling tired even with good sleep | **0** | **1** | **2** | **3** |  |
| 9. Feeling worthless, low self-esteem | **0** | **1** | **2** | **3** |  |
| 10. Decreased interest in previously enjoyed activities | **0** | **1** | **2** | **3** |  |
| 11. Feeling hopeless, things will never change | **0** | **1** | **2** | **3** |  |
| 12. Thoughts of suicide or death | **0** | **1** | **2** | **3** |  |
| 13. Seriously contemplating/planning suicide | **0** | **1** | **2** | **3** |  |
| 14. Sleep problems-too much or too little | **0** | **1** | **2** | **3** |  |
| 15. Decreased interest in sex | **0** | **1** | **2** | **3** |  |
| 16. Preoccupation with sexual thoughts/activities | **0** | **1** | **2** | **3** |  |
| 17. Appetite or weight markedly up or down | **0** | **1** | **2** | **3** |  |
| 18. Episodes of binge eating (with or without vomiting) | **0** | **1** | **2** | **3** |  |
| 19. Excessive worry about weight/body image | **0** | **1** | **2** | **3** |  |
| 20. Irritable mood, snapping at others, easily angered | **0** | **1** | **2** | **3** |  |
| 21. Episodes of rage, really “losing” it | **0** | **1** | **2** | **3** |  |
| 22. Unexplained “up” mood, restless, lots of energy | **0** | **1** | **2** | **3** |  |
| 23. Impulsive behavior that you wouldn’t: normally” do | **0** | **1** | **2** | **3** |  |
| 24. Racing thoughts that you cannot control | **0** | **1** | **2** | **3** |  |
| 25. Seeing/hearing things others tell you are not real | **0** | **1** | **2** | **3** |  |
| 26. Feeling nothing or “numb” emotionally | **0** | **1** | **2** | **3** |  |
| 27. Recurrent, intrusive thoughts or images | **0** | **1** | **2** | **3** |  |
| 28. Easily startled, overly “watchful” | **0** | **1** | **2** | **3** |  |
| 29. Feeling you are watched or talked about by others | **0** | **1** | **2** | **3** |  |
| 30. Difficulty trusting others and feeling safe | **0** | **1** | **2** | **3** |  |
| 31. Persistent fears about health problems despite doctors finding  nothing wrong | **0** | **1** | **2** | **3** |  |
| 32. Occupational concerns: job dissatisfaction, problems with  employer or co-workers | **0** | **1** | **2** | **3** |  |
| 33. Parenting concerns, difficulty managing children | **0** | **1** | **2** | **3** |  |
| 34. Relationship problems with spouse or other(s) | **0** | **1** | **2** | **3** |  |
| 35. Use of caffeine (coffee, cola, tea, Mt. Dew, etc.) | **0** | **1** | **2** | **3** |  |
| 36. Smoking cigarettes | **0** | **1** | **2** | **3** |  |
| 37. Drinking alcohol (beer, wine, liquor) | **0** | **1** | **2** | **3** |  |
| 38. Use of prescription drugs in non-prescribed ways | **0** | **1** | **2** | **3** |  |
| 39. Use of marijuana, cocaine, or other street drugs | **0** | **1** | **2** | **3** |  |