

ADULT INTAKE INVENTORY

Name: _____ Date: _____

Date of birth: _____ Place of birth: _____

SS #: _____ Referred by: _____

Address: _____

Cell phone: _____ Work phone: _____ Home phone: _____

Please tell us your contact preferences: _____

PERSONAL INFORMATION

Gender: Female Male Race: _____

Sexual orientation: Heterosexual Homosexual Bisexual Prefer not to answer

Education completed: High school/GED Community college College Graduate school
Other: _____

Plans for continuing education? Yes No Uncertain Would like to

Employment status: _____ Occupation: _____

Employer _____

Religious preference: _____

Military service and discharge information: _____

Please mark the answer that best describes your childhood:

Very happy Happy Average Unhappy Very unhappy

Who raised you (check all that apply):

Biological parents Parent and step-parent Single parent (mother) Single parent (father)

Adoptive parents Foster parents Relatives Unrelated friend(s) of family

How many siblings do you have? _____ What birth order are you? _____

RELATIONSHIPS

Marital status: Married Divorced Separated Widowed Cohabitate Single

Spouse's name: _____

Is your spouse living with you? Yes No

Spouse's employer: _____ Spouse's occupation: _____

How long married? _____ #Children from this marriage: _____

If not married, which best describes your relationship status:

Live-in companion Dating Engaged to be married No involvement

Are you happy with your relationship status? Yes No Prefer not to answer

Previous marriages: _____ # Previous live-in companions: _____

Full-term pregnancies: _____ # Abortions: _____ # Miscarriages: _____

List all your children below (include biological children, stepchildren, adopted children, foster children):

Name	Age	Relationship to you	Does this child live with you now?

Who else lives with you? _____

Are you being physically, sexually, or emotionally abused? Yes No

If yes, who is hurting you? _____

Do you have a plan for safety? Yes No

Would you like me to help you develop a plan for safety? Yes No

HEALTH INFORMATION

LIST ALL YOUR MEDICATIONS ON THE SEPARATE FORM PROVIDED.

Who is your primary physician? _____

When was your last medical examination? _____

What was the purpose of your last visit? _____

Please list any allergies you have, including any allergies or allergic reactions to medications:

Health Status: Excellent Very good Good Average Poor

Are you now or could you be pregnant? Yes No

Please list present symptoms and/or medical conditions: _____

Are you currently being treated for these problems? Yes No

Who is treating you? _____

Ever have a head injury or trauma? Yes No If yes, when?_____

Knocked unconscious? Yes No If yes, when?_____

If you sustained a head injury, were you treated? Yes No

Please list surgeries, handicaps, learning disabilities, etc.:_____

SUBSTANCE USE

Do you smoke cigarettes? Yes No Previously

If yes, when did you start?_____ How much do you smoke?_____

Have you ever tried to quit? Yes No If yes, when was last attempt?_____

If you previously smoked, how long has it been since you quit?_____

Do you consume alcoholic beverages? Yes No

If yes, age of first use?_____

Do you drink every day? Yes No If yes, how much?_____

If no, do you drink every week? Yes No If yes, how much?_____

When did you last consume alcoholic beverages?_____ How much?_____

Do you wake up sweaty, shaky, feeling sick and/or needing a drink? Yes No

Do you have hangovers? Yes No

What is the most you drink during drinking episodes?_____

What is the average amount you drink during drinking episodes?_____

Does anyone complain about your drinking? Yes No If yes, who?_____

Do you worry about your drinking? Yes No

Have you tried to stop? Yes No If yes, when was last attempt?_____

Do you use any other substance (i.e., cannabis, pain pills, meth, cocaine)? Yes No

If yes, please answer the following as accurately as possible:

Substance	When was last use?	Age at first use?	How much do you use each time?	How do you use this substance?

Have you ever been admitted to detox for any substance? Yes No

If yes, when?_____ What substance?_____

List any current or past legal problems because of your use of alcohol or other drugs:

Did your mother drink or drug during any of her pregnancies? Yes No Don't know

If yes, how do you know? _____

If you are pregnant, are you currently drinking or using other drugs? Yes No

If yes, what substances are you using? _____

How much are you using? _____ How often are you using? _____

Have you spoken to your doctor about your use? Yes No

COUNSELING

List all previous counseling, psychotherapy, psychiatric or substance abuse treatment below:

Have you ever been admitted to a psychiatric or mental health unit? Yes No

If yes, please provide information below:

Date of Admission	Date of Discharge	Reason for Admission	Voluntary, Yes or No

What problems would you like to discuss?

In case of emergency, whom would you like us to notify? _____

Address: _____

Phone #: _____

Relationship to client: _____

(Please note, we may ask you to sign an Authorization for this person)