WHITE OAK Counseling and Recovery
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ADULT INTAKE FORM

To help your clinician understand your concerns, please answer the following questions on this form and bring it with you to your first appointment.

Client's Legal Name:_____ **DOB:** _____

Gender Identity (optional)

☐ Male ☐ Female ☐ Transgender ☐ Cisgender ☐ Non-binary

Sexual Identity (optional)

☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Pansexual ☐ Undecided

RACE/ETHNICITY (optional)

Please check the box that best represents your race/ethnic background. Please check all that applies.

☐ African-American/Black ☐ Arab American ☐ Asian or Pacific Islander ☐ Hispanic ☐ Multi-racial ☐ Native American
☐ White/Caucasian ☐ Other: _____ or check all that apply

HISTORY OF PRESENT PROBLEM (symptoms, onset, duration, etc.)

What is your reason for seeking therapy today?_____

_____

_____

PAST PSYCHIATRIC HISTORY

Previous Counseling:

Outpatient (place and year)_____

Inpatient (place and year) _____

Intensive Outpatient Program/Partial (place and year)_____

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

FAMILY PSYCHIATRIC HISTORY

Do you have any family members that have been diagnosed with mental conditions (depression, attempted suicide)?

☐ Yes ☐ No If yes, what? _____

What is their relationship to you?_____

MEDICAL CONDITIONS & HISTORY *(Optional)*

Please check all medical issues for which you have had treatment:

☐ Allergies
(e.g., allergic reactions, seasonal allergies, etc.)

☐ Bone disease
(e.g., osteoporosis, arthritis, broken bones, etc.)

☐ Blood disease
(e.g., anemia, bleeding disorders, etc.)

☐ Digestive system disease
(e.g., ulcers, heartburn, Celiac Disease, IBS, etc.)

☐ Endocrine disease
(e.g., diabetes, hypothyroid, low testosterone etc.)

☐ Genetic disease
(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc.)

☐ Head and brain illness or injury
(e.g., fainting, concussion, seizures, dementia, etc.)

☐ Heart/cardiovascular disease
(e.g., heart arrhythmia, heart attack, high blood pressure)

☐ Immune disease
(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc.)

☐ Lungs and breathing disease
(e.g., asthma, COPD, emphysema, etc.)

☐ Mouth and teeth disease
(e.g., gum disease, cold sores, canker sores, etc.)

☐ Muscle and movement disease
(e.g., tremors, tics, restless legs, Parkinson's, etc.)

☐ Poisoning & chemical exposure
(e.g., overdose, lead exposure, work fumes, etc.)

☐ Serious injuries and wounds
(e.g., burns, cuts, stabs, crushed limbs, etc.)

☐ Other: _____

Do you have problems with pain? ☐ Yes ☐ No

If yes: Severity of your pain? (low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high)

Location of your pain: _____

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home?
☐ Yes ☐ No If yes, please explain: _____

_____

CURRENT MEDICATIONS

Please list all current medications and supplements you are currently taking:
(Attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

Have you had an allergic reaction to medication(s)? ☐ Yes ☐ No If yes, list below:
Name of medication: _____ Explain reaction: _____

Name of medication: _____ Explain reaction: _____

SUBSTANCE USE

Do you use alcohol? ☐ Yes ☐ No If yes, number of drinks and frequency: _____

Do you use recreational/illicit drugs? ☐ Yes ☐ No

If yes, drug(s) of choice and frequency: _____

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

Have you ever tried to cut down on your alcohol or drug use or quit using? ☐ Yes ☐ No

If yes, please explain: _____

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

If yes, please explain: _____

Have you had any prior substance abuse treatment? ☐ Yes ☐ No If yes, list below:

When? **Where?**

_____ _____

_____ _____

FAMILY AND SUPPORTIVE RELATIONSHIPS

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Committed partnership

Name	Age	Relationship (e.g. Spouse, Child, Friend, Neighbor, Roommate, Parents)	Quality of Relationship?	Living with you?
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No

Please describe what life was like growing up (please include siblings, step-siblings, and birth order). _____

_____

_____

SOCIAL HISTORY

Were you sheltered/kept private? ☐ Yes ☐ No Did you relate well to others? ☐ Yes ☐ No

SPIRITUALITY/RELIGIOUS BACKGROUND AND PRACTICE

Religious upbringing: ☐ Nonexistent ☐ Attending Church ☐ Belief in God ☐ Other _____

Present practice: ☐ Inactive ☐ Active ☐ Searching ☐ Other _____

DEVELOPMENTAL HISTORY

Childhood diagnoses of ADHD? ☐ Yes ☐ No Autism? ☐ Yes ☐ No Other _____

_____

EDUCATIONAL / OCCUPATIONAL HISTORY

Highest level completed:

☐ High School ☐ Attended college or technical school ☐ College degree ☐ Graduate degree Other_____

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Stay-at-home Parent

Finances: Overall stress level: ☐ High ☐ Medium ☐ Low

LEGAL HISTORY

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

If yes, please explain:_____

_____

Do you currently have a probation or parole officer? ☐ Yes ☐ No

If yes, name:_____

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

If yes, please explain:_____

_____

SNAP (strengths, needs, abilities, preferences)

Strengths: _____

Needs: _____

Abilities: _____

Preferences: _____

DSM-5 – Rated Level 1 Cross-Cutting Symptom Measure – Adult

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? *(circle appropriate answer, 0-4)*	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2. Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III.	4. Sleeping less than usual, but still have a lot of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	5. Starting lots more projects than usual or doing more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	7. Feeling panic or being frightened?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8. Avoiding situations that make you anxious?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10. Feeling that your illnesses are not being taken seriously enough?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VI.	11. Thoughts of actually hurting yourself?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XII.	19. Not knowing who you really are or what you want out of life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	20. Not feeling close to other people or enjoying your relationships with them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? *(circle appropriate answer, 0-4)*	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	22. Smoking any cigarettes, a cigar, or pipe, using snuff or chewing tobacco?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], or drugs like marijuana, cocaine, or crack, club drugs [like ecstasy], hallucinogens [like LSD], heroin, inhalants or solvents [like glue], or methamphetamine [like speed])?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

Are there other concerns (not listed above) that you want to discuss? _____

_____

_____

OTHER IMPORTANT INFORMATION

_____

_____

_____

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_____

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_____

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Client Signature _____ **Date:** _____

THANK YOU!