Ashley Mullica, MSW, LCSW

ADULT INTAKE FORM

Please complete and bring to your first session. Please note that the information you provide here is protected as confidential information.

Name:_____
Last First Middle Initial

Date of Birth:_____/_____/_____ **Age:**_____ **Gender:**_____

Marital Status:_____ **Children/Age:**_____

Address:_____
Number Street City State Zip

Home Phone:_____ **Cell Phone:**_____

Email:_____ **May I email you? Y N**
***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Preferred method of contact: Cell Phone Home Phone Email Text

Please circle the issue(s) for which you are seeking treatment:

Marriage/Relationship	**Family Problems**	**Physical/Disability**
Trauma/PTSD	**Moodiness**	**Sleeping**
Grief/Loss	**Loneliness**	**Eating**
Anxiety/Worry	**Self-Esteem**	**Anger**
Depression	**Work/School**	**Concentration**
Alcohol	**Drugs**	**Sexual Issues**
Social Problems	**Memory Problems**	**Financial**

Please explain:_____

_____

How much has this problem affected your life? (Please circle the best answer)

1	2	3	4	5	6	7	8	9	10
Very Little									**a great deal**

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Have you previously received any type of mental health services (therapy/medication management, etc)? Y N

If yes, previous therapist and details/dates of treatment: _____

_____

Are you currently taking any prescription medication? Y N

Please list:_____

_____

Have you ever been prescribed psychiatric medication? Y N

Please list and provide dates:_____

_____

Have you ever been psychiatrically hospitalized? Y N

If yes, when, where and for what reason:_____

_____

Any history of suicide attempts? Y N

If yes, please provide details including dates/methods: _____

_____

Any history of cutting? Y N

If yes, please provide details: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Excellent

Please list any health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise?_____

What types of exercise?_____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing sadness, grief or depression? Y N

If yes, please explain and for how long?_____

_____

6. Are you currently experiencing anxiety, panic attacks, or phobias? Y N

If yes, please explain and for how long?_____

_____

7. Are you currently experiencing any chronic pain? Y N

If yes, please describe:_____

_____

8. Do you consume alcohol? Y N

If yes, please provide your current alcohol consumption (amount and frequency):

_____

9. Have you ever had a problem with alcohol? Y N

If yes, please explain including dates/treatment:_____

_____

10. Do you use any recreational drugs? Y N

If yes, please provide type, amount and frequency:_____

_____

11. Have you ever had a problem with drug use? Y N

If yes, please explain including dates/treatment:_____

_____

12. Are you currently in a romantic relationship? Y N

If yes, for how long?_____

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On a scale of 1-10, how would you rate your relationship?_____

13. What significant life changes or stressful events have you experienced recently including losses/trauma/moves/work/family/relationships/etc:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandmother, uncle, etc).

	Please Circle		Family Member
Alcohol/Substance Abuse	**Y**	**N**	
Anxiety	**Y**	**N**	
Panic Attacks/Phobias	**Y**	**N**	
Depression	**Y**	**N**	
Eating Disorder	**Y**	**N**	
Bipolar Disorder	**Y**	**N**	
Schizophrenia	**Y**	**N**	
Suicide Attempts	**Y**	**N**	
Obsessive Compulsive Behavior	**Y**	**N**	
Domestic Violence	**Y**	**N**	
Abuse	**Y**	**N**	

ADDITIONAL INFORMATION

1. Are you currently employed? Y N

If yes, what is your current employment situation?

_____

Do you enjoy your job? Is there anything stressful about your current position?

_____

2. What is your highest level of education? _____

3. Do you consider yourself to be spiritual or religious? Y N

If yes, describe your faith or belief:

_____

4. Do you have any hobbies/interests/sports/etc?

_____

_____

5. What are your current coping skills? How do you take care of yourself?

_____

_____

_____

6. What do you consider to be some of your strengths?

_____

_____

_____

7. What do you consider to be some of your weaknesses?

_____

_____

_____

8. What would you like to accomplish out of your time in therapy/why are you seeking help?

_____

_____

_____

_____

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