



Adult Intake

Please take the following lines to explain how we can best help you on your journey right now or what leads you to seek services now (we will go into this in more detail at your visit):

A. Identification Information

Name: _____ DOB: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

May we leave messages at these numbers? No Yes

Email: _____ May we send emails to this address: No Yes

B. Referral:

How did you find out us (please circle one)? Friend Relative Advertisement Seminar

Other: _____

C. Previous Psychological Treatment:

Have you received previous psychological treatment? No Yes

If "Yes" please provide the following information:

When	Duration	By Whom	For What	Results

Have you taken medications for mental health purposes? No Yes

If "Yes" please provide the following information:

Medication	When	Duration	By Whom	For What	Results

D. Relationships:

Describe your relationship with your mother in the past and present:

Describe your relationship with your father in the past and present:

Describe your relationship with your sibling(s) in the past and present:

Describe your relationship with your most recent significant other/spouse/partner and the duration of this relationship and name of the person:

Describe the nature of your closest friendships, duration, qualities, and such:

E. Mental Health History:

Has anyone in your family been diagnosed with a mental health disorder including addiction(s)?

No Yes

If yes, please provide the following information:

Who	Diagnosis	When	Treatment Sought?	Results

F. Abuse History

Were abused as a minor? No Yes

If you were abused, please provide the following information using these letters for the Abuse Type:

P = Physical such as beating, slapping, pushing

S = Sexual such as touching, molesting, fondling, or intercourse

N = Neglect such as failure to feed, shelter, protect, provide medical treatment

V = Verbal such as name-calling, shaming, belittling

Your Age	Abuse Type	By Whom	Effects on you	Whom did you tell	Consequences of telling

G. Primary Adult Relationship History

Current marital status: ___Married ___Divorced ___Single ___Widowed

If widowed, please provide the following information:

Marriage	Your age when began	Years Married	Cause of spouse's death	Number of children and ages
1				
2				
3				

If divorced, please provide the following information:

Marriage	Your age when began	Your age when ended	Was divorce high-conflict?	Reason for ending
1				
2				
3				

Are there children from divorced marriage(s)? No Yes

If yes, please provide following information:

Marriages	Number of children	Ages	Who has custody?	
1				
2				
3				

H. Education Information:

Highest level of education received: _____ Year: _____

Degree(s) received: _____

I. Employment Information:

Job Title	Dates Held	Employer	Reason for leaving

J. Religious Identification:

Religious affiliation/denomination: _____

Involvement: ___None ___Some/Irregular ___Active

How important are spiritual concerns in your life? _____

Do you want spiritual topics/concerns incorporated into your treatment? _____

K. Chemical Use: Please answer completely and honestly

How many alcoholic drinks (including wine and beer) do you consumer/week? _____

Has alcohol consumption ever created problems in your life? No Yes

If yes, please explain: _____

Have others ever complained to you about your alcohol consumption? No Yes

Do you smoke cigarettes? No Yes If yes, how many packs/day? _____

Please provide complete and honest answers below regarding illegal substance use:

Chemical	Last use	Amount	How often used	How long used
Marijuana				
Cocaine/Crack				
Inhalants				
LSD				
Prescribed pills				
Heroin				
Specify Other				

Which if these have you experienced due to alcohol and/or illegal substance use:

___Blackouts ___Withdrawal symptoms ___Cravings ___Overdoses ___N/A

Have you ever been treated (including hospitalization) for alcohol and/or illegal substance use/abuse? No Yes

If yes, please provide the following information:

Dates	Agency	Type of Program	Voluntary? Yes/No	Length of Treatment	Effects of Treatment

Have you ever experienced legal problems (including arrest) due to alcohol and/or use of illegal substances? No Yes

If yes, please explain: _____

L. Health Information

Starting with childhood and proceeding to the present, list all major diseases, illnesses, important accidents and injuries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had not including pregnancies.

Age	Illness/Diagnosis	Length of Illness	Medications Taken	Effects of Treatment

How many hours sleep/night do you average? _____

Is this consecutive or broken sleep? _____

How many hours of exercise do you average/week? _____

What is your exercise of choice? _____

How many meals do you average/day? _____

Would you describe your diet as poor, average, healthy? _____

For women only:

Do you struggle with your weight? No Yes

If yes, how and what efforts have you made to lose and/or maintain your weight?

How many pregnancies have you had? _____

Have you had any miscarriages or abortions? No Yes

If yes, how many and when: _____

Menstrual period questions:

How regular are your periods?

What are your primary PMS symptoms? _____

What types of hormonal treatments/medications have you or are you currently taking?

Menopause questions:

If you are in menopause, what age did it start?

What age did it finish?

What types of hormonal treatments/medications have you or are you currently taking?

M. Presenting Symptoms: Please mark all of the items below that apply to you, and feel free to add any others at the bottom under "Other concerns or issues." You are welcome to add a note or details next to those you mark.

___ Abuse experienced: physical, sexual, emotional, neglect

___ Aggression, violence

___ Alcohol use/abuse/addiction

___ Anger, hostility, arguing, irritability

___ Anxiety, nervousness

___ Attention, concentration, distractibility

___ Career goals, concerns, and choices

___ Childhood issues (your own)

___ Codependence

___ Confusion

___ Custody battle regarding children, visitation conflicts

___ Decision making, indecision, mixed feelings

___ Delusions

___ Dependence

___ Depression, low mood, sadness, crying

___ Divorce, separation

___ Drug use – prescription, over-the counter, illegal substances

___ Eating problems – overeating, under eating, vomiting

- ___ Emptiness
- ___ Failure
- ___ Fatigue, tiredness, low energy
- ___ Fears, phobias
- ___ Financial troubles, debt, impulsive spending, low income
- ___ Friendships
- ___ Gambling
- ___ Grieving, mourning, deaths, losses, divorce
- ___ Guilt
- ___ Headaches, other kinds of pain_____
- ___ Health, illness, medical concerns, physical problems
- ___ Housework, chores – quality, schedules, sharing duties
- ___ Inferiority feelings
- ___ Interpersonal conflicts
- ___ Impulsiveness, loss of control, outbursts
- ___ Irresponsibility
- ___ Judgment problems, risk taking
- ___ Legal matters, charges, suits, probation
- ___ Loneliness
- ___ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ___ Memory problems
- ___ Menstrual problems, PMS, menopause
- ___ Mood swings
- ___ Motivation (lack thereof), laziness
- ___ Nervousness, tension
- ___ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ___ Oversensitivity to rejections
- ___ Panic or anxiety attacks
- ___ Parenting, child management, single parenthood
- ___ Perfectionism
- ___ Pessimism
- ___ Procrastination, work inhibitions
- ___ Relationship problems (with friends, relative, co-workers)
- ___ School problems
- ___ Self-centeredness
- ___ Self esteem
- ___ Self-neglect, poor self-care
- ___ Sexual issues, dysfunctions, conflicts, desire differences
- ___ Shyness, oversensitivity to criticism
- ___ Sleep problems – too much, too little, insomnia, nightmares
- ___ Smoking and tobacco use

- ___ Spiritual, religious, moral ethical issues
- ___ Stress, inability to relax, stress management, tension
- ___ Suspiciousness
- ___ Suicidal thoughts
- ___ Temper problems, low frustration tolerance, violent tendencies
- ___ Thought disorganization, confusion
- ___ Weight and diet issues
- ___ Withdrawal, isolating
- ___ Work problems, unemployment, workaholism, inability to keep job

Other concerns or issues: _____

Of the concerns you noted, which one is of the most concern _____

What results would you like to see in therapy? _____

When was the last time you considered yourself happy and/or content? _____

What are your current hobbies? _____

What else is important for your clinician to know? _____

Thank you for the time and effort you have spent in completing this Intake form!

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.



CREDIT CARD AUTHORIZATION

Please make no marks or add comments to this page of the document

It is your consent to make payment for services rendered and time allotted for your treatment or assessment and these professional services are conditional on your signing this consent form without modification. This form will be securely stored in your client file and may be updated upon request at any time.

If you miss or fail to cancel an appointment within 48 business hours of the scheduled time, or if a check is returned unpaid, you will be charged for the time allotted for your appointment. With appropriate notice, appointment slots can almost always be used to serve another client. An additional \$25 fee will be assessed for returned checks or inaccurately disputed charge-backs.

I, _____, hereby authorize Dr. Alexis Llewellyn or Katy Center for Psychology & Counseling Services to charge my credit card at a rate of \$200 per hour for the individual time allotted me and \$225 per hour for couples or family appointments per hour allotted to us including all of the following:

- *Missed appointments/no shows
- *Appointments that I have cancelled with less than 48 business hours notice
- *Returned checks or chargebacks from PayPal in which an additional \$25 will be added to the total

Credit Card/Debit Card Type (check one):

Visa MasterCard Discover American Express

Card # _____ Expiration Date: _____
Verification/Security Code (3-digit code on back of card or 4-digit code on front): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Email address that may be used to send notification of payment: _____

By signing below I am authorizing Dr. Alexis Llewellyn or Katy Center for Psychology & Counseling Services to charge my credit card for professional services as described above. I understand that credit card transactions require release of some of my identifying information and consent to this release. I certify that I am the owner of the credit card listed on this page and can thereby authorize this card to be charged:

Signature: _____ Date: _____

Printed Name: _____