Elizabeth T. Rieger, MSW LISW-S, LLC
1330 Park Way Ct.
Beavercreek, OH 45432
Phone: 937-203-8141
Fax: 937-306-6995

Adult History Intake Form

Please fill out this biographical form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy Form and the HIPPA Notice of Privacy Practices. If you choose not to answer a particular question, please write, "Do not care to answer."

Name: _____ Male/Female: _____ Date: _____ Date of Birth: _____

Age: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How do you prefer I contact you? _____ Which numbers are okay to leave a message? _____

Email: _____ Emergency contact person/#: _____

Who referred you to me? _____ Is it okay to send them a "thank you"? _____

Risk Assessment: (underline all that apply):

Suicidality	Not Present	Ideation	Plan	Means	Prior Attempt
Homicidality	Not Present	Ideation	Plan	Means	Prior Attempt

List of Current Symptoms: (Please check all that apply.)

- ❑ Depressed Mood
- ❑ Decreased Energy
- ❑ Grief
- ❑ Hopelessness
- ❑ Feelings of Worthlessness
- ❑ Guilt
- ❑ Nervousness/Anxiety
- ❑ Panic Attacks
- ❑ Obsessions/Compulsions
- ❑ Elevated Mood
- ❑ Irritability
- ❑ Hyperactivity
- ❑ Disruption of Thought Process/Content
- ❑ Delusions
- ❑ Hallucinations
- ❑ Paranoia
- ❑ Dissociative States
- ❑ Oppositional
- ❑ Somatic Complaints
- ❑ Medical Illness
- ❑ Impulsivity
- ❑ Emotional/Physical/Sexual Victim of Trauma
- ❑ Emotional/Physical/Sexual Perpetrator of Trauma
- ❑ Substance Use (check one)
  - ❑ Active Substance Use
  - ❑ Early Full Remission
  - ❑ Early Partial Remission
  - ❑ Sustained Partial Remission
  - ❑ Other (specify): _____
- ❑ Other (specify): _____

Symptoms have been present for:

❑ Less than 1 month ❑ 1 to 6 months ❑ 7 to 12 months ❑ 1 to 3 years ❑ More than 3 years

Current Impairment **Impairment Level** (circle one)

Categories	**No Impairment**	**Mild Impairment**	**Moderate Impairment**	**Marked Impairment**	**Extreme Impairment**
Marriage/Relationship/Family	1	2	3	4	5
Job/School/ Performance	1	2	3	4	5
Friendship/Peer Relationships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Hobbies/Interests/Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Legal Status (Arrest,Probation)	1	2	3	4	5
Activities of Daily Living (Personal Hygiene, Bathing, etc.)	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

PROBLEM DESCRIPTION

In your own words, what difficulties are you currently experiencing?_____

_____

When did these difficulties first being? _____

Was there a specific incident or event which seemed to cause these difficulties to begin? _____

If so, what? _____

What have you done on your own to attempt to resolve these difficulties? _____

_____

How have these attempts worked? _____

Have you contacted other professionals for help with these concerns? _____

If so, whom? _____When? _____For how long? _____

What aspects of this were most helpful? _____

Least helpful? _____

FAMILY HISTORY

By whom were you raised? _____

Where did you grow up? _____ Urban, rural, small town, etc. _____

Parents' education (highest grade completed): M _____ F _____

Parents' Occupation: M _____ F _____

Please list all brothers and sisters including first names and their ages, from oldest to youngest, including yourself in the appropriate position: _____

_____

Did any of the following happen to you? If yes, indicate the ages(s) at which they took place:

- ❑ Death of Mother _____
- ❑ Death of Father _____
- ❑ Death of Sibling _____
- ❑ Separation of Parent _____
- ❑ Parental Divorce _____
- ❑ Physical Abuse (by whom) _____
- ❑ Serious Illness (self) _____
- ❑ Desertion of Mother _____
- ❑ Desertion by Father _____
- ❑ Parent(s) alcoholic/addictions_____
- ❑ Long-term family illness_____
- ❑ Mental illness in family_____
- ❑ Sexual abuse (by whom?) _____
- ❑ Adopted _____

Use this space if you want to explain more about any of the above: _____

_____

Describe your mother's personality and her attitude toward you, past and present: _____

_____

Describe your father's personality and his attitude toward you, past and present: _____

_____

Describe what your home life was like as you were growing up: _____

_____

CURRENT FAMILY/SIGNIFICANT OTHERS

(Please circle all that apply): Single Boyfriend/Girlfriend Engaged Married Separated Divorced Widowed

List those living with you, their ages, and relationship to you: _____

_____

How many times have you been married? _____Dates of marriages? _____

How did these marriages end, and when? _____

Do you have children not living with you? _____ If yes, list them, why they live elsewhere, and the quality of your relationship with them now? _____

_____

Who are the most important people in your life? _____

Briefly describe the positive qualities or your current marital/romantic relationship(s): _____

_____

If the quality of your sexual relationship(s) is an issue you wish to address in therapy, please indicate below:

_____

How many people have you dated since the onset of adolescence? _____ Do you think you dated enough before making a commitment to a relationship? _____ Are there other important aspects of your current significant relationships that you would like to add? _____

_____

SOCIAL RELATIONSHIPS

How often do you socialize with others? _____ How many friends do you have who you see socially at least once per month? _____ What sorts of activities do you participate in with them? _____

_____

Do you have close friends with whom you can discuss your problems, interests, and concerns? _____

What hobbies or leisure activities do you pursue? _____

Estimate how many hours per day you spend online (social networking, gaming, browsing, etc.): _____

Do you feel your technology use is balanced and healthy or could it use improvement? Please explain:

_____

MEDICAL/PHYSICAL FUNCTIONING

Height: _____ Weight _____ Last Physical Exam: _____Any abnormal or irregular

findings? _____

Name of family physician/practice? _____

Address: _____ Phone: _____

Check any of the following you have had:

- ❑ Breathing Problems
- ❑ Dizziness/Fainting
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Heart Condition
- ❑ Diabetes
- ❑ Neurological Problems
- ❑ Endocrine Problems
- ❑ Cancer
- ❑ Pregnancy/Abortion
- ❑ Epilepsy/Convulsion
- ❑ Headaches
- ❑ Other (list): _____

List any surgeries you have had and dates: _____

_____

List any current medical conditions/concerns: _____

_____

List any medication you are currently taking:

Medication	Dosage	# times daily	Why prescribed

Any adverse side effects that you have to any medications: _____

Check those that you currently experiencing:

❑ Sleep Problems – too much ❑ too little ❑ early awakening ❑ frequent awakening ❑
sleepwalking ❑ hard to fall asleep ❑

❑ Eating Problems – too much ❑ too little ❑ eating when not hungry ❑

List any allergies you have: _____

MENTAL HEALTH HISTORY

Have you ever been treated by a mental health professional or by your physician for emotional or mental health issues? _____ (If no, skip this section)

Name of professional and/or facility, and dates of treatment:

_____ _____

_____ _____

_____ _____

May I request your treatment records from them? _____

What were the issues you brought to the above named professionals? _____

_____

Were the issues resolved? How? _____

What aspects of treatment were most helpful? _____

Least helpful? _____

Describe any fearful or distressing experiences not previously mentioned: _____

_____

SUBSTANCE USE AND DEPENDENCY

How often do you currently use the following substances?

	Daily	3-5 times/week	1-2 times/week	2-3 times/month	1/month	Seldom	Never
Beer	❑	❑	❑	❑	❑	❑	❑
Wine	❑	❑	❑	❑	❑	❑	❑
Marijuana	❑	❑	❑	❑	❑	❑	❑
Cocaine	❑	❑	❑	❑	❑	❑	❑
Crack	❑	❑	❑	❑	❑	❑	❑
Barbituates	❑	❑	❑	❑	❑	❑	❑
Amphetamines	❑	❑	❑	❑	❑	❑	❑
Tranquilizer	❑	❑	❑	❑	❑	❑	❑
Analgesics	❑	❑	❑	❑	❑	❑	❑
Heroin	❑	❑	❑	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑	❑	❑	❑
Other (list)	❑	❑	❑	❑	❑	❑	❑

Have you ever had job, relationship, financial legal, social, or physical problems as a result of your substance use? _____ Desribe: _____

Has anyone in your family been involved in treatment for substance use or dependency? _____

Who and what substances? _____

Have you or others in your family been involved in treatment for substance use or dependency? _____

Describe: _____

Have you ever been involved in 12-step group (AA, Al-Anon, etc.)? _____ Currently? _____

What groups? _____

BEHAVIORAL ADDICTIONS

Do you consider yourself to be addicted to activities or behaviors which are not chemical in nature (food, television, gambling, sex, etc.) _____ If so, what? _____

Any prior treatment for these? _____If so, what? _____

EDUCATIONAL/OCCUPATIONAL FUNCTIONING

Current occupation: _____ Length of time? _____

Do you consider your occupation fulfilling for you? _____ Are you considering changing jobs? _____

Have you had any disciplinary actions against you at work? _____If so, what? _____

If you could have any job you wanted, what would you choose? _____

List your highest educational achievement: _____ Your grades were: Above average Average Below Average

Extracurricular activities you participated in: _____

If you left high school before graduation, note the reason: _____ GED? _____

MILITARY HISTORY

What are you/did you do in the service? _____

What is/was your highest rank? _____ Any demotions, court martials, etc.? _____

Where were you stationed and when? _____

Were you ever hospitalized in the service? _____ If so, for how long? _____

Do you receive compensation for a service disability? _____Discharge received? _____

LEGAL HISTORY

Have you ever been convicted of a felony? _____ Details: _____

Are you currently on probation or parole? _____ Details: _____

Have you been ordered to receive counseling and/or other services as a result of your involvement with the legal system? _____ Explain: _____

SENTENCE COMPLETION

Below are a list of partial sentences. Please complete the phrase with the first thought that enters you mind.

1. I feel nervous about _____
2. I like _____
3. When I was a child, I _____
4. What I like best about myself is_____
5. What I like least about myself is _____
6. Other people say I'm _____
7. What really makes me angry is _____
8. I feel sad when I think about _____
9. Most men _____
10. My mother _____
11. I need _____

12. My greatest worry is _____

13. People _____

14. I failed at _____

15. I am best when _____

16. I secretly _____

17. Most women _____

18. I hate _____

19. The future _____

20. My father _____

21. My mind _____

22. What pains me _____

23. Children _____

Please list below anything that has not been asked that you believe is important information:

_____

_____

List the benefits you hope to derive from therapy. This is very important. Please be specific.

1. _____

2. _____

3. _____

Do you think you would be helped more by (circle all that apply)

a. Directions to change specific behaviors
b. Talking about your problems individually
c. Psychological testing
d. Medication
e. Group therapy
f. Family therapy