2500 Willamette Falls Dr. #105,
West Linn, OR 97068

Mental Wellness 360*

Adult Intake Form **Date** _____

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session. If you would rather discuss something in person, please leave it blank.

Name:_____ Date of Birth (DOB):_____

Address:_____

_____

Home phone:_____ May I leave a message? Yes No

Cell phone:_____ Leave message or text? Yes No

Work phone:_____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

(For appointment scheduling purposes only, an email not considered a confidential medium of communication).

Spouse or Partner's Name (if applicable): _____

How did you hear about or who referred you to my private practice?

_____

I use this for tracking purposes only. In order to preserve confidentiality, I will not contact them.

What is the main reason you're seeking help? (Please include how long you've had these symptoms or problems): _____

_____

_____

_____

What are your goals for therapy?_____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Do you currently have any medical problems? _____

_____

_____

Have you ever been treated for any of the following? If so, please circle and describe:

Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

_____

_____

_____

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

Have you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Please list current prescription and non-prescription medications with dosage (psychiatric and general health):

Please list any previous psychiatric medications (with dosage and dates):

Do you drink alcohol or use recreational drugs (including smoking and marijuana)? If so, what kind and how often?

Do you or anyone close to you consider your use to be a problem? Yes No

Who is your primary care physician?

Who is your psychiatrist (if applicable)?

When was your last complete physical exam (month/year)?

How many times a week do you exercise? What type and how many minutes?

What kinds of foods do you regularly eat?

YOUR FAMILY GROWING UP (Family of Origin)

	MOTHER	**FATHER**
Current age, or If deceased date, age, and cause of death		
Country of Origin		
Religious/Spiritual Affiliation (if any)		
Use 3 adjectives or more to describe <u>each</u> parent		
How did you and <u>each</u> parent get along when you were growing up?		

Give some examples of things that you did together & feelings you had.		
Use 3 adjectives or more to describe your parents' relationship		
How did your parents get along? What were any things they disagreed over?		
Years married or together		
If divorced or not together, your age at divorce		
Reason for divorce/split		
Describe your relationship with step-parents (if any)		
List anyone else who lived with you <u>or</u> regularly cared for you		
Were you adopted? Age?	**If so, please write any relevant information about your biological parents.**	
List any major problems in your family growing up:		

Siblings

Please list all of your brothers and sisters in the order of birth.

First name	Biological (Yes/No)	Current Age	Male/ Female	Married or Partnered? (Yes/No)	Describe your relationship in a few words

Yourself

Where were you born? _____

Where did you live most of your childhood? _____

What was the highest grade of education you completed _____

When you were a child, did you struggle with any of the following: Age

Learning disabilities	Yes	No	_____
Hyperactivity	Yes	No	_____
Bed wetting	Yes	No	_____
School fears	Yes	No	_____
Teasing/Bullying	Yes	No	_____
Eating disorders	Yes	No	_____
Witnessing violence in the home	Yes	No	_____
Sexual, physical or emotional abuse	Yes	No	_____

If so, at what age and by whom (sibling or adult abuse)? _____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Depression	Yes	No	_____
Suicide Attempts	Yes	No	_____
Bipolar/Manic Depressive	Yes	No	_____
Alcoholism	Yes	No	_____
Substance Abuse	Yes	No	_____
Domestic Violence	Yes	No	_____
Eating Disorders	Yes	No	_____
Obesity	Yes	No	_____
Schizophrenia	Yes	No	_____
Counseling or Psychotherapy	Yes	No	_____
Psychiatric Hospitalizations	Yes	No	_____

CURRENT FAMILY, SOCIAL SUPPORTS, OCCUPATION & LIFE INTERESTS/ACTIVITIES

Intimate Relationships & Social Supports

Are you currently married? Yes No How long?_____

Are you currently partnered/in a romantic relationship? Yes No How long? _____

Do you have any concerns about your current marital or romantic relationship that you would like to discuss? If so what are they?

Are you currently separated or divorced? Yes No How long? _____

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication: _____

Please describe your social relationships. Do you have friends and/or extended family? What do you do for fun? Socialize? Whom can you turn to for emotional and other forms of support?

Children

Please list your biological, adopted and/or stepchildren (if applicable)

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Describe your relationship in a few words

Employment and/or Current Educational Situation

Are you currently employed? Yes No Are you currently a student? Yes No

Please describe your current work or academic situation: _____

Do you enjoy your work/school? Is there anything stressful about it? _____

Interests/Activities/Spirituality

What are some of your interests & activities? _____

Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable)

Would you like your spirit/faith to be included in sessions?_____

How much are each of the following areas currently a problem for you?

	Not at all **1**	**A little** **2**	**Somewhat** **3**	**Considerably** **4**	**Terribly** **5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Marital Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Job/School	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder/Struggles	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Have you experienced any unusually severe stresses during the last year? Yes No

If yes, please describe:_____

_____

_____

What do you consider to be your strengths?_____

What do you consider to be your areas of needed growth?_____

Is there any other information you'd like to add? _____

_____

_____

_____

_____