

ADULT INTAKE ASSESSMENT FORM

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Please answer all of the following questions to the best of your ability.

IDENTIFYING INFORMATION

Name: _____ Today's Date: _____

Male Female Date of Birth: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell/other phone: _____

Is it OK to contact you at home? Yes No OK to leave a message? Yes No

Special calling instructions? _____

Business phone: _____

Is it OK to contact you at work? Yes No OK to leave a message? Yes No

Special calling instructions? _____

How did you learn about my services? _____

OCCUPATION/EMPLOYMENT INFORMATION

Check all that apply: employed retired disabled student homemaker unemployed

If/When employed, what type of work do you do? _____

Current employer: _____ Years on Current Job: _____

Are you currently having difficulties on the job because of (Check if yes):

emotional problems?

substance abuse?

Have you ever had difficulties at work because of (Check if yes):

emotional problems?

substance abuse?

If yes to any of the above, please explain: _____

Ever in Military Service: yes no

Currently in military? yes no Branch: _____

If you served in combat, when did you serve? _____

Type of discharge: _____

Reason for discharge: _____

MARITAL STATUS

Marital/relationship status (Check one): Married; Live with partner (check if same ___ or opposite ___ sex); Single; Separated/Divorced; Widowed; or Other: _____

MARITAL STATUS (continued)

If previously married, please provide dates of Marriage(s): _____

Number of years currently married: _____

Are you experiencing any problems/stresses in your current marriage/relationship? yes no

Did you experience any problems/stresses in your previous marriage/relationship? yes no

Comments regarding stresses in current or previous marriage(s)/relationship(s): _____

If you have had problems in the past, what do you think caused those relationships to end? _____

EDUCATION

Last grade completed in school/college is/was: _____ Degree: _____

Are you currently enrolled in school? yes no Major/focus: _____

Do you have any special training, skills, or certification? (list): _____

Do you have any problems reading or writing? yes no

Do you have any difficulty understanding (check any that apply): spoken instructions
 written instructions
 demonstrated instructions

How do you learn best? _____

What was school like for you? _____

Describe any difficulties or problems you had/have in school: _____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems you are experiencing. A therapist will discuss this in more detail with you shortly. _____

What has happened to cause you to seek help NOW? _____

What do you hope to be able to do or achieve as a result of treatment? _____

What do you consider to be the other stresses in your life? _____

HISTORY OF THE PROBLEM

When did you first start experiencing the problem(s) that bring you to the clinic today? _____

How often does the problem occur? _____

How long does it last? _____

Do you currently have thoughts of harming yourself? yes no

Do you currently have thoughts of wishing you were dead? yes no

Do you currently have urges to hurt, harm, or kill someone else? yes no

If yes, whom? _____

Have you ever seriously considered suicide or felt like harming someone else? yes no

If yes, please explain: _____

Do you have any problem with any of the following: overspending food binging

intentional vomiting yelling/threatening risk taking/ endangering self or others

hitting, shoving, choking, or hurting others throwing or breaking things

stealing internet overuse or misuse sexual feelings/behaviors

Have you ever had previous therapy/counseling of any kind? yes no

If yes, when and for how long? _____

What concerns did you address in previous therapy? _____

Have you ever been hospitalized for emotional problems? yes no

Have you ever been hospitalized for substance abuse problems? yes no

If yes to either of the above, when, where, and for how long were you hospitalized? _____

Were any of your previous treatment experiences helpful? yes no

Please explain how you benefited or did not benefit from previous treatment: _____

What medication(s), if any, have you found helpful in managing your emotional problems? _____

Have you had any experience with self-help support groups? yes no

If yes, please explain when, which ones, and whether or not you found them helpful: _____

SUBSTANCE USE HISTORY

Have you ever experienced a problem with alcohol, drugs, or prescription medications? yes no

If yes, please explain: _____

SUBSTANCE USE HISTORY (continued)

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications?

yes no If yes, please explain: _____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? yes no

If, yes, please explain: _____

Have you had any problems related to use of alcohol/drugs in the past year? yes no

If, yes, please explain: _____

Has drinking or drug use ever caused you problems in the following areas (check if yes):

family school employment legal emotional social financial behavior physical health
 other, please describe: _____

FAMILY BACKGROUND

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN

<u>Names of children</u>	<u>Living with you?</u>	<u>Age</u>	<u>Grade</u>	<u>School</u>
1. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
2. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
3. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
4. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
5. _____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____

Other than any children already indicated above, who lives in your household? _____

Please describe your relationships with other family members:

<u>Relationship</u>	<u>Living?</u>	<u>Frequency of contact?</u>	<u>Describe quality of relationship</u>
Father	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Mother	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Step-father	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Step-mother	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Spouse/partner	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Sister(s)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Brother(s)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____
Other _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	_____	_____

Whom were you raised by? _____ Were you adopted? yes no

Please list the age and sex for each of your brothers/sisters (including those deceased, and please indicate if any are step-siblings): _____

FAMILY BACKGROUND (continued)

What family member(s) are you closest to now? _____

As you were growing up, what adult(s) stood out as people you could really trust? _____

Check the statement(s) below that describe the type of family you grew up in:

- overly close family no "breathing room" everyone was in everyone else's business
- no privacy boundaries not respected Comfortably close family loving
- shared many positive experiences supportive distant, everyone did their own thing
- not much time spent together not a lot of support angry, lots of fighting/hostility
- verbal abuse and conflicts violence frightening scared to make mistakes
- other descriptors: _____

Have any biological relatives ever had any emotional problems or substance abuse? yes no

If yes, please explain: _____

Has anyone in your family ever attempted or committed suicide? yes no

If yes, please explain: _____

RACE/ETHNICITY

RELIGIOUS AFFILIATION

	Self	Spouse		Self	Spouse
European-American	_____	_____	Catholic	_____	_____
African-American	_____	_____	Jewish	_____	_____
Hispanic-American	_____	_____	Muslim	_____	_____
Native-American	_____	_____	Protestant	_____	_____
Asian-American	_____	_____	Non-Denominational	_____	_____
Other _____	_____	_____	Eastern (e.g., Hindu, Buddhist)	_____	_____
			Other _____	_____	_____

HEALTH/MEDICAL INFORMATION

<u>Physician</u>	<u>Address & Telephone #</u>	<u>Approx Date of last visit</u>
_____	_____	_____
_____	_____	_____

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____

Do any of these problems affect your everyday life? yes no If yes, how so? _____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): _____

HEALTH/MEDICAL INFORMATION (continued)

Have you ever had a serious head injury? yes no If so, describe: _____

Are you allergic to any medications? yes no If yes, which one(s): _____

List all medications that you currently use:

<u>Medication(s)</u>	<u>Dosage (amount and times per day)</u>	<u>Reason(s)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any "alternative" therapies/treatments you are currently using and the reason for each: _____

Have you ever had or do you now have a problem with any of the following? (Check all that apply):

General

- Recent Fever/Chills
- Chronic Fatigue
- Frequent or Terrifying Nightmares
- Night Sweats
- Insomnia or Sleep Problems
- Chronic Pain
- Diabetes
- Cancer
- Drug Reaction
- Emotional Problems
- Allergies
- Exposure to Trauma (Type: _____)
- Cigarette Smoking
- Other Tobacco Use
- Alcohol Use
- Drug Use
- Suicide Attempt(s)

Gastrointestinal/Hepatic/Endocrine

- Nausea
- Gastritis
- Ulcers
- Vomiting Blood
- Pancreatitis
- Gall Bladder/Stones
- Jaundice
- Gallbladder/Stones
- Jaundice
- Hepatitis
- Constipation
- Diarrhea
- Colitis
- Rectal Bleeding
- Hemorrhoids
- Liver Problems
- Hemorrhoids
- Liver Problems
- Weight Loss/Gain
- Change in Appetite
- Anemia
- Thyroid Problems
- Always Thirsty
- Swollen Glands
- Low Blood Sugar
- Swollen Glands
- Low Blood Sugar

Musculoskeletal

- Broken Bones
- Bad Back
- Herniated Disk
- Muscle Weakness
- Joint Pain H
- Arthritis
- Gout

Cardiovascular

- Angina
- Fainting
- Lightheadedness
- Irregular Heart Beat
- High/Low Blood Pressure
- Rheumatic Fever
- Heart Valve Problems

Pulmonary

- Chest Pains/Pressure
- Shortness of Breath
- Cough
- Wheezing/Asthma
- Coughing Blood
- Tuberculosis
- Pneumonia

HEALTH/MEDICAL INFORMATION (continued)

Neurological

- Headaches
- Migraines
- Skull Fracture
- Epilepsy
- Stroke
- Paralysis
- History of Head Injury
- Double Vision
- Memory Loss
- Unsteady Gait

Urinary/Genital

- Frequent Urination
- Burning on Urination
- Weak Urinary System
- Incontinence
- Urinary Tract Infection
- Blood in Urine
- Kidney Infection
- Penis/Vaginal Discharge
- Menstrual Difficulties
- Sexual Difficulties
- STD

Skin/Sensory Systems

- Sores/Abscesses
- Skin Rash
- Eye Trouble
- Hearing Loss
- Ringing in Ears
- Perforated Septum
- Nose Bleeds
- Gum Bleeding
- Mouth Sores
- Difficulty Swallowing

INTERESTS AND ACTIVITIES

Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently: _____

Please describe your personal strengths and positive characteristics: _____

Other information you feel is important and wasn't asked about: _____

Thank you for your time and cooperation.

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