Patient Information

For office use only, please do not write in this box.

THE WHITTIER PAVILION OUTPATIENT CLINIC

Adult Intake Packet

Please complete the following items thoroughly and accurately. Do not leave any blanks. If you need additional space please feel free to use the back of this form. When complete, please turn this packet into the front desk staff.

Client's name:_____ Date:_____

Address:_____

City, State:_____Zip:_____

Phone Numbers : Home ( )_____ Can we leave a message? Yes ☐ No ☐
Work ( )_____ Can we leave a message? Yes ☐ No ☐
Cell ( )_____ Can we leave a message? Yes ☐ No ☐

Email address:_____

Circle one: Female Male
Birth date:_____Age:_____Social Security Number:_____

Employer:_____
Position:_____

Marital/relationship status:_____
Significant other's name (If applicable):_____
Name and ages of all children in the home (If applicable):_____

Who shall we contact in case of emergency?
Name:_____Phone( )_____

In this box, please indicate the address and telephone number you want us to use when sending bills or when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above.

Family Information

Names & Do they live with you?	M/F	Age	Living/Deceased	Relationship (i.e. positive/negative/ contact/no contact)	Substance abuse/medical/mental health diagnoses
Client:					
Mother:					
Father:					
Siblings:					
1.					
2.					
3.					

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Names & Do they live with you?	M/F		Living/Deceased	Relationship (i.e. positive/negative/ contact/no contact)	Substance abuse/medical/mental health diagnoses
Children/Step-children					
1.					
2.					
3.					
Other:					

Medical Information

List any allergies:_____None_____
Primary Care Physician:_____Address_____
City:_____State:_____Zip:_____
Primary Care Physician's Phone Number: ( )_____
Date of your most recent physical examination:_____
Pharmacy Name:_____Address:_____
City:_____State:_____
Pharmacy Phone Number: ( )_____

Please list all of your current medications both prescribed and over the counter medications and frequency and dosages: (if you need more room, please write on the back of this form)

Name of medication	Dosage	How often do you take it	Reason for taking it	Name of Prescriber	When did you start taking it?

Please list all current or past health problems, or any major surgeries:

Current	Past

Have you had prior counseling or therapy (When? Where? Reason?)_____
_____
Have you ever been hospitalized for psychiatric treatment? No___Yes___ Where and when (month/year)?_____
_____
_____
What brings you to counseling now?_____
How long have your current concerns existed?_____
Describe severity of your present concerns: (circle one) Mild Moderate Severe

Mental Health History:

Please check all that apply (current or in the past):

	Self	Family Member (Indicate relationship)		Significant Other
Anxiety Disorder	____	_____	_____	_____

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Please check all that apply (current or in the past):

	Self	Family Member (Indicate relationship)		Significant Other
Dissociative Disorder	____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____
Impulse Control Disorder	_____	_____	_____	_____
Mood Disorder	_____	_____	_____	_____
Sexual Disorder	_____	_____	_____	_____
Sleep Disorder	_____	_____	_____	_____
Psychotic Disorder	_____	_____	_____	_____
Substance Disorder	_____	_____	_____	_____
Somatoform Disorder	_____	_____	_____	_____
Personality Disorder	_____	_____	_____	_____
Other:	_____	_____	_____	_____
Verbal/Emotional Abuse	_____	_____	_____	_____
Physical Violence	_____	_____	_____	_____
Sexual Assault	_____	_____	_____	_____
Sexual Abuse	_____	_____	_____	_____
Self-Injury/Cutting	_____	_____	_____	_____
*Suicidal Ideation/Thoughts/ Attempts	_____	_____	_____	_____
*Homicidal Ideation/Thoughts/ Attempts	_____	_____	_____	_____

*Please specify currently or in the past _____

Below is a list of problems people sometimes experience. Carefully read each problem. Please check each issue which is causing you distress:

Interpersonal Concerns

_____Developing independence from family
_____Making friend's
_____Dating/social anxiety
_____Shyness, being ill at ease with people
_____Breakup/loss of relationship
_____Relationship violence/abuse
_____Relationship with friends/peers
_____Relationship w/ family/parents/siblings
_____Homesickness
_____Assertiveness problems
_____Dissatisfaction with social life
_____Romantic relationships
_____Grief or loss issues

Academic/Career problems

_____Academic Work/Grades
_____Perfectionism
_____Uncertain about goals
_____Learning disability
_____Work difficulties
_____Career decisions
_____Performance/Test Anxiety
_____Reading/Study Skills
_____Procrastination/motivation

Clinical Concerns

_____Anxiety/fears/worries
_____Sleeping problems
_____Concentration difficulty
_____Stress
_____Self esteem/confidence
_____Fatigue
_____Over eating
_____Under eating
_____Irritability/anger/hostility
_____Hearing voices
_____Self injury/cutting
_____Alcohol use/ abuse
_____Drug use/abuse
_____Other

Physical concerns

_____Head injury/aches
_____Nutritional concerns
_____PMS
_____Surgeries
_____Chronic Pain
_____HIV/AIDS concerns
_____Chronic illnesses
_____Other

Sexual Concerns

_____Sexual Dysfunction
_____Sexually transmitted diseases
_____Abortions
_____Pregnancy
_____Miscarriages

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Identity/Value Concerns

_____Religious/spiritual concerns

_____Sexual identity/orientation concerns

_____Ethnic/racial concerns

Other concerns

_____Financial problems

_____Other-specify

_____Legal problems (please specify):_____

Please mark all that apply:

_____crying spells
_____always worried
_____feelings easily hurt
_____dizziness
_____constipation
_____feeling grouchy
_____always tired
_____poor appetite
_____depressed
_____trouble sleeping
_____feeling lonely
_____loss of weight
_____not enjoying things
_____nausea or vomiting
_____feeling inferior
_____loss of sexual interest
_____no one understands me
_____worried about health
_____can't concentrate
_____feeling fearful
_____feeling angry
_____lack energy

_____fast heartbeat
_____relationship concerns
_____frequent sweating
_____sexual problems
_____shaky hands
_____stomach trouble
_____nightmares
_____feeling tense
_____cold feet and hands
_____feeling panicky
_____diarrhea
_____fighting and quarreling
_____muscle twitching
_____full of energy
_____can't make decisions
_____easily excited
_____headaches
_____fainting spells
_____unable to relax
_____very restless
_____feeling like hurting someone
_____weight gain

_____excessive overeating
_____feel like smashing things
_____binge eating
_____impatient with people
_____dislike my body
_____excessive drinking
_____excessive medication use
_____excessive drug use
_____problems with children
_____problems with parents
_____ poor physical health
_____overly ambitious
_____quick tempered

_____ _____

Patient Signature Date/Time