EMERALD COAST COLLABORATIVE SOLUTIONS

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Today's Date: _____

INDIVIDUAL INTAKE FORM

Thank you for taking the time to complete this intake form. Please note that the information you provide here is protected as confidential information. Please complete all items if possible. If you have any questions, please ask.

I. IDENTIFICATION

Your name: _____ Birthdate: _____
Spouse/Partner: _____ Birthdate: _____
Marital status (please circle one)
Married | Never Married | Separated | Divorced
List child(ren) and ages: _____
_____
Home address: _____
Street City State Zip Code
Home phone number: _____ May we leave a message? _____
Cell: _____ May we leave a message? _____
Email address: _____ May we email you? _____
Occupation: _____ Employer: _____
Referred by (if applicable): _____

II. PRESENTING PROBLEM(S)

Please give a description of the presenting problem or major complaint that brings you in here today:

_____
_____
_____
_____
_____
_____
_____
_____

Please give a brief description of the history of the problem and how you have tried to handle it:

_____
_____
_____
_____
_____

III. YOUR MENTAL HEALTH HISTORY

Have you previously received any mental health or substance abuse services? _____

Date	Facility	Inpatient/Outpatient	Diagnosis

What do you consider to be the top three stressors in your life?

1) _____
2) _____
3) _____

Psychological Symptoms

Emotions: Select any of the following that you find troubling and/or applied to you in the last month.

_____Anxious
_____Angry
_____Bored
_____Confused
_____Contented
_____Distrustful
_____Energetic
_____Easily excitable
_____Fearful
_____Frustrated
_____Guilty
_____Happy
_____Hopeless
_____Jealous
_____Lonely
_____Relaxed
_____Restless
_____Sad
_____Suspicious
_____Tense
_____Other: _____

Behaviors: Select any of the following that you find troubling and/or applied to you in the last month.

_____Aggression
_____Attention problems
_____Avoiding activities
_____Avoiding/people/places
_____Concentration problems
_____Crying
_____Decreased energy
_____Decreased interests
_____Employment difficulty
_____Flashbacks
_____Hurting self
_____Hurting others
_____Impulsiveness
_____Increased drinking
_____Increased energy
_____Increased smoking
_____Isolation
_____Loss of control
_____Nightmares
_____Overeating
_____Oversleeping
_____Risk taking
_____Spending sprees
___Taking mood altering drugs
_____Temper outbursts
_____Under eating
_____Vomiting
_____Under sleeping
_____Fearful
_____Other: _____

Do you drink alcohol? _____ If yes, how much each time? _____
How often do you engage in recreational drug use?

Daily | Weekly | Monthly | Occasionally | Never

Are you experiencing overwhelming grief or depression? If so, for how long: _____
Are you experiencing anxiety, panic attacks, or phobias? If so, for how long: _____
Dou you feel you would be better off dead? _____
Have you ever attempted suicide? _____If yes, what were the circumstances? _____
_____
_____

IV. FAMILY MENTAL HEALTH HISTORY

Is there a family history of any of the following? Please indicate which family members may have experienced any of the following.

Alcoholism (who and for how long?): _____
_____
_____

Substance abuse (who and for how long?): _____
_____
_____

Mental illness (who and for how long?): _____
_____
_____

Serious illness or hospitalizations (who and for how long?): _____
_____
_____

Is there any history of physical, emotional, verbal, or sexual abuse? _____
If yes, please list victims, including yourself: _____
_____
_____

V. MEDICAL HISTORY

Your medical information is used to detect possible medical conditions that may require a physician's attention (your primary care provider). Responses may result in recommendation that you consult with your physician for further examination.

Your Physician's Name: _____Phone: _____

Current medications and dosage: _____
_____
_____

Please check the symptoms or conditions that have applied to you at any time.

_____Alcoholism	_____Diabetes	_____Hearing problems
_____Allergies	_____Eating problems	_____Heart disease
_____Anemia	_____Epilepsy	_____Hepatitis
_____Cancer/tumors	_____Head trauma	_____High blood pressure
_____Kidney disease	_____Seizures	_____Stroke
_____Liver disease	_____Smoking	

Please check the symptoms or conditions that frequently apply to you.

_____Abdominal pain
_____Fainting
_____Impulsiveness
_____Hurting self
_____Hurting others
_____Other: _____

VI. About Your Education

What is the highest level of education you have completed? _____

While in school, did you have a learning disability that required additional services? If so, please describe: ____
_____
_____

While in school, did you have behavioral problems? If so, please describe: _____
_____
_____

VII. Relationship Information (if applicable)

On a scale of 1 – 10, least satisfactory to most satisfactory, how would you rate your relationship? _____

What difficulties are you facing in your relationship? _____
_____
_____

Have you or your partner threatened to separate or divorce as a result of the current problems? _____
If yes, please explain: _____
_____

How frequently have you had sexual relations in the last month? _____

On a scale of 1 – 10, least satisfactory to most satisfactory, rate the following questions:

1. How enjoyable is your sexual relationship? _____
2. How satisfied are you with the frequency of your sexual relations? _____
3. To what degree do your family or friends support you as a couple? _____
4. To what degree do you and your partner share a similar world view? _____

VIII. Additional Information

What is your current job description? _____
_____

On a scale from 1 – 10, how well do you enjoy your job and why? _____
_____

Do you have legal problems? If so, please explain: _____
_____

Are you court ordered to come into treatment? If so, who is the referral source and what are the requirements and circumstances surrounding it? _____
_____
_____

Please describe at least five significant strengths you consider to possess:

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe what you consider to be some weaknesses you possess:
_____
_____

Thank you!

Additional Comments/Notes: