Connections WA

Connections WA, Adult Intake Form

Please complete the following intake form with as much information as possible, to help us outline your current needs for therapy. Leave blank any question you would rather not answer, or would prefer to discuss in session.

ABOUT YOU

Name:_____DOB:_____
Address: _____
Mobile: _____Email:_____
Next of Kin (name) _____(relationship to you)_____
Mobile:_____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counselling or psychology elsewhere? Yes ( ) No ( ), with (therapist's name) _____

Have you previously received psychiatric, counselling or psychology services?
Yes ( ) No ( ), with (therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? Yes ( ) No ( ) If yes, please list, dose frequency, response:
_____
Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Who is your primary physician and name of practice?
_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:
_____
_____
_____

Are you currently on medication to manage a physical health concern? If yes, please list:
_____
_____

Any substance use (type, amount, duration, circumstances, impact on MH? Past/Current/None
_____
Current living situation:_____
Support/agencies involved:_____

What are your Interests:_____
Current stressors:_____

How many times per week do you exercise? _____
Approximately how long each time? _____

Are you having any problems with your sleep habits? ( ) Yes ( ) No
If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dream ( ) Other _____

Are you having any difficulty with appetite or eating habits? ( ) No ( ) Yes
If yes, check where applicable:
( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting ( ) Other _____

Have you experienced significant weight change in the last 2 months?
( ) No ( ) Yes

Do you regularly use alcohol? ( ) No ( ) Yes
In a typical month, how often do you have 4 or more drinks in a 24 hour period?
_____

How often do you engage recreational drug use?
( ) Daily ( ) Weekly ( ) Monthly ( ) Rarely ( ) Never

Do you smoke cigarettes or use other tobacco products? ( ) Yes ( ) No

Have you had suicidal thoughts recently?
( ) Frequently ( ) Sometimes ( ) Rarely ( ) Never

Have you had them in the past?
( ) Frequently ( ) Sometimes ( ) Rarely ( ) Never

Are you currently in a romantic relationship? ( ) No ( ) Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship?
_____

In the last year, have you experienced any significant life changes or stressors?
If yes, please explain:
_____
_____
_____

OCCUPATIONAL INFORMATION
Are you currently employed? ( ) No ( ) Yes
If yes, who is your currently employer and position?_____
If yes, are you happy with your current position_____

Please list any work-related stressors, if any
_____
_____
_____
_____

Have YOU ever experienced any of the following?

Extreme depressed mood	Yes / No	
Dramatic mood swings	Yes / No	
Rapid speech	Yes / No	
Extreme anxiety	Yes / No	
Panic attacks	Yes / No	
Phobias	Yes / No	
Sleep disturbances	Yes / No	
Hallucinations	Yes / No	
Unexplained losses of time	Yes / No	
Unexplained memory lapses	Yes / No	
Alcohol/substance abuse	Yes / No	
Frequent body complaints	Yes / No	
Eating disorder	Yes / No	
Body image problems	Yes / No	
Repetitive thoughts (e.g. obsessions)	Yes / No	
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No	
Homicidal thoughts	Yes / No	
Suicidal attempts	Yes / No	

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) No ( ) Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) No ( ) Yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member/s**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

OTHER INFORMATION

What do you consider to be your strengths?

_____

_____

What do you like most about yourself?

_____

_____

What are effective coping strategies that you have learned?

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

Thank you for completing these questions, they help us to quickly obtain information so that we can use our time more effectively together.

The Connections WA team