Lindsay A. Solomon, Psy.D.
Licensed Psychologist

Adult Client Intake Form

Date: ____________

Name: ______________________________ **Date of birth:** __________**Age:** ______**Gender:** ______

Home street address: ____

City: _________________________**State:** ____________**Zip:**___________**County:**_______________

Home Phone: _____________________________**Work Phone:** _____________________________

Cell Phone: _________________________**Email:** ____

Calls and emails will be discreet, but please indicate any restrictions and/or preferences for communications: ____

Name and number of individual to contact in case of emergency: _______________________

____

Please check if applicable:

High School/GED____College Degree______Graduate Degree(or Higher)____Vocational Degree_____

Are you currently employed? _______**Name of Employer:** _____________________________

If so, what do you do? ____

Employment Satisfaction: POOR **1 2 3 4 5 6 7** EXCELLENT

Please briefly describe your presenting concern(s): ____________________________________

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How long have you had these concerns? ____

What are your goals for therapy? ____

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How long do you expect to be in therapy in order to accomplish these goals? ___________

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How did you hear about my psychotherapy practice? ______________________________

Medical Information

Please explain any significant medical problems, symptoms, or illnesses): _____________

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How many hours of sleep do you get per night? ______________

Do you have difficulty falling asleep? ❑Yes ❑No If yes, how often? ___________________

Do you frequently wake up in the middle of the night? ❑Yes ❑No

If yes, how often? _______________________

Do you have frequent nightmares? ❑Yes ❑No If yes, how often? ____________________

Current Medications

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? ❑Yes ❑No If yes, how often? ________________________

Do you consume caffeine? ❑Yes ❑No If yes, how often? ________________________

Do you drink alcohol? ❑Yes ❑No If yes, how often? ________________________

Do you use any non-prescription drugs? ❑Yes ❑No If yes, what kinds and how often?

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Have any of your friends or family members voiced concern about your substance use?
❑Yes ❑No If yes, please explain____

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Have you ever been in trouble or in risky situations because of your substance use?
❑Yes ❑No If yes, please explain: ____

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Who is your Primary Care Provider? ______________________________________

Have you ever made a suicide attempt/gesture? ❑Yes ❑No If yes, please explain:

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____

Have you ever been admitted to a psychiatric hospital? ❑Yes ❑No

Approximate date and reason: ____

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Have you ever been in therapy? ________________**Length of Therapy:** ________________

Reason for therapy: ____

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Reason for termination of therapy: ____

Family and Relationship Information

Are you married/life partnered? ❑Yes ❑No Length of marriage/partnership: _________

Were you previously married/life partnered? ❑Yes ❑No If so, length of previous marriages/committed partnerships: ____

Are you currently in a relationship? ❑Yes ❑No Length of current Relationship: ________

Relationship Satisfaction: (POOR) **1 2 3 4 5 6 7** (EXCELLENT)

Do you have Children? ❑Yes ❑No If yes, how many? ________**Ages:** ________________

Please list the names and relations of individuals who live in your household

Names	M/F	Age	Relationship

Please describe family mental health/psychiatric history (depression, anxiety, etc.):

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Please describe recent significant family events or stressors (recent move, divorce, marriage, job loss, death): ______________________________

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Is there a history of sexual abuse/physical abuse or trauma? ❑Yes ❑No
If yes, please explain: ______________________________

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What do you believe are your strengths? ______________________________

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PLEASE CHECK ALL THAT APPLY AND ***CIRCLE*** THE MAIN PROBLEM(S):

❑ Anxious	❑ Severe weight loss	❑ Nightmares
❑ Sadness/Depression	❑ Difficulty with parents	❑ Nausea
❑ Mood Changes	❑ Difficulty with children	❑ Abdominal distress
❑ Easily angered or bad temper	❑ Marriage/Partnership conflict or problems	❑ Fainting
❑ Panic	❑ Problems with friends	❑ Dizziness
❑ Fears	❑ Problems with co-worker(s)	❑ Shortness of breath
❑ Irritability	❑ Employer	❑ Chest pain
❑ Poor Concentration	❑ Finances	❑ Sweating
❑ Headaches	❑ Legal problems	❑ Heart palpitations
❑ Loss of memory	❑ Sexual concerns	❑ Muscle tension
❑ Excessive Worry	❑ Grief	❑ Fidget frequently
❑ Feeling manic or elevated mood	❑ History of child abuse (physical abuse, neglect)	❑ Hyperactivity
❑ Difficulty trusting others	❑ Domestic violence	❑ Chills or hot flashes
❑ Difficulty communicating with others	❑ History of sexual abuse/rape	❑ Easily distracted by noises
❑ Drugs	❑ Thoughts of hurting someone else	❑ Often make careless mistakes
❑ Excessive alcohol	❑ Thoughts of suicide	❑ Frequent crying
❑ Excessive caffeine	❑ Sleeping too much	❑ Severe weight gain
❑ Frequent vomiting	❑ Sleeping too little	❑ Other:

Any additional information that you would like to include: ______________________________

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