Brandywine Valley Counseling
And Neurofeedback Center

ADULT INTAKE FORM

Name: _____ Date:_____
Date of Birth: _____
Address:

Home Phone: _____ Cell Phone: _____
E-mail address: _____
How did you hear about us?

Insurance company: _____
Insurance ID number: _____
Insurance group number: _____
Insurance phone number (behavioral health):_____

Marital Status: _____
List any children with ages: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalizations, etc.)? If yes, please give names and approximate dates of treatment.

If so, was there anything particularly helpful or unhelpful about these services?

Medications and dosages:

Allergies to foods or medications:

Emergency Contact: _____
Phone number: _____ Relationship to you: _____

GENERAL PHYSICAL AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please List any specific health problems you are experiencing:

Please list any physical injuries or head impacts (even without loss of consciousness), including car accidents, slips and falls, surgeries, etc.:

2. How would you rate your current sleeping habits?

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in?

4. List any difficulties you experience with your appetite or eating patterns:

Do you feel that you get enough proteins and nutrients in your diet?

5. Are you currently experiencing sadness, grief, or depression? If so, for how long?

6. Are you currently experiencing anxiety, panic attacks or phobias? If so, for how long?

7. Are you experiencing any chronic or intermittent pain? If yes, please describe.

8. Please describe your alcohol use (how much, how often):

9. Please describe your recreational drug use (how much, how often):

10. Are you currently in a romantic relationship? If so, for how long?

Please rate your relationship satisfaction on a scale of 1-10 _____

11. What significant life changes or stressful events have you experienced lately? What are the precipitating factors that have caused you to seek out services?

FAMILY MENTAL HEALTH HISTORY

Please indicate if there is a family history of the following, as well as the family member's relationship to you (ex. father, grandmother, aunt, etc.)

Condition	Yes or No	Family member(s)
Depression	_____	_____
Anxiety	_____	_____
Alcohol/Substance Abuse	_____	_____
Domestic Violence	_____	_____
Other abuse	_____	_____
Eating Disorders	_____	_____
Obsessive Compulsive Behavior	_____	_____
Schizophrenia	_____	_____
Suicide attempts	_____	_____

PERSONAL/FAMILY HISTORY

1. Did you have any behavioral or academic problems as a child? If so, please explain.

2. Were there any special circumstances in your home (ex. divorce, illness, intense arguing, deaths, etc.)? If so, please briefly explain.

3. Did you experience any physical, emotional and/or sexual abuse in childhood or adolescence? If so please briefly explain.

ADDITIONAL INFORMATION

1. Are you currently employed or in school? If so, what is your current employment or school situation?

Do you enjoy your work/school? Is there anything stressful about it?

2. Do you consider yourself to be spiritual and/or religious? If so, please describe your faith or belief.

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish in your time with us?