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Intake Form: Adult

Chief Concern:

What is the main problem (concern) for which you are seeking mental health services?

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____

Apt.: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ e-mail: _____

Home Phone: _____

Calls or e-mail will be discreet, but please indicate any restrictions:

B. Referral: How did you hear about InSight? _____

C. Religious and racial/ethnic identification (Optional)

Current religious denomination/affiliation

Protestant Catholic Jewish Islamic Buddhist Hindu

Other (specify): _____

Involvement: None Some/irregular Active

How important are spiritual concerns in your life?

Ethnicity/national origin: _____ Race: _____

or other similar way you identify yourself and consider important:

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

E. Your current employer

Employer: _____

Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

G. Your education and training

	Credits Earned	Special/remedial classes?	Adjustment to school?	Did you graduate? Degree earned.
High School				
Community college/Trade School				
Four-year college				

H. Family-of-origin mental health history

Name of Relative	Current age	Mental Health Problem?	Education	Occupation
Father				
Mother				
Brothers				
Sisters				
Stepfather				
Stepmother				

I. Marital/relationship history

	Spouse's name	Spouse's age when married.	Your age when married or widowed	You're age when divorced.	Did spouse remarry:
First Marriage					
Second					
Third					

J. Significant nonmarital relationships (Relationships that have had a profound and lasting effect on you)

	Name of other person	Person's age when started relationship	Your age when started relationship	You're age when ended	Reasons for ending
Current					
Past relationship					
Past relationship					

K. Children Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age age	Gender	Grade in School	Adjustment problems	Indicate "P" if applicable.

L. Is there any other information you think we should know?

Chemical Use Survey

In order to treat you effectively, I need information about the ways you and your family have used alcohol, drugs, and/ or other chemicals that can affect you psychologically. So please answer these questions fully.

A. What have you used?

1. ____ I have **never** used an illicit substance/chemical.
2. ____ I have **never** abused prescription medication.
3. Think about all chemicals you have used, and indicate how much you used (amount) and how often. Then indicate all the effects it had on you (mental, physical, family, legal, etc.).

Chemical	Age Started	Date of Last use	Over the last 30 days, amount and how often used	Effects/consequences
Caffeine				
Tobacco				
Marijuana/THC				
Cocaine/Crack				
Inhalants/Huffing				
LSD "shrooms"				
Prescribed Pills				
Others: Specify				

***Write "P" above next to your primary drug of choice.**

***For each chemical you currently use, what causes you to stop? Enter one or more of these letters in the last column above: A = The money runs out. B = I use up my supply. C = Personal choice. D = Unconsciousness. E = Achieved my purpose. F = Other reasons:**

4. What are, or were your sources of money for buying the chemicals you have used?

B. Which of these have you had due to chemical use? Blackouts Bad reactions Withdrawal symptoms Cravings
Overdoses

- Tolerance ("Could not get high no matter how much I used") Preoccupation (Spent lots of time finding and using chemicals) Failed attempts to cut down or control use Detoxification in a hospital
 Other problems:

C. Family patterns of chemical use

Please describe the chemical(s) used by family members.

	Type of substance	Amount and how often	Effects on individual
Father			
Mother			
Brothers/			
Sisters			
Spouse/partner			
Other relatives			

Please add any other information you think is important:

D. Treatment for chemical use

Dates From-->To	Agency/provider	*Type of program	Voluntary (yes or no)	Length of treatment	Participation in aftercare programs	†Effects of Treatment

*In the third column, use these codes: AA/NA = Alcoholics Anonymous/Narcotics Anonymous; O = Outpatient counseling; ID = Inpatient detoxification; IT = Inpatient treatment (e.g., 28-day); O = Other.

†In the last column, use these codes: W = made situation Worse; N = No change; U = better Understanding of addiction; R = Reduction of use; BA = Brief abstinence (up to a month); LA = Long-term abstinence (several months or more); O = Other effects:

F. Self-description of use

Would you say you: are a social drinker? are a heavy drinker? have alcoholism? have a drinking problem?
Or how would you describe your use

Would you say you: are a recreational drug user? have a drug problem? have an addiction? Or how would you describe your use? _____

G. Other

Has your drinking/drug use caused you any spiritual problems?

Adult Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Pain, chronic
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also "Career concerns ...")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness, distrust
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- Other concerns or issues:

Limits of the Therapy Relationship: What Clients Should Know

Psychotherapy is a professional service I can provide to you. Because of the nature of therapy, our relationship must be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a “dual relationship,” which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

I want to explain why having a dual relationship is not a good idea. Dual relationships can set up conflicts between my own (the therapist's) interests and your (the client's) best interests, and then your interests might not be put first. In order to offer all my clients the best care, my judgment needs to be unselfish and professional.

Because I am your therapist, dual relationships like these are improper:

- I cannot be your supervisor, teacher, or evaluator.
- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts.
- I cannot provide therapy to people I used to know socially, or to former business contacts.
- I cannot have any other kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you, or trade or barter your services (things like tutoring, repairing, child care, etc.) or goods for therapy.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. As your therapist, I cannot be your friend. Friends may see you only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may need to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that therapists are required to keep the identity of their clients secret. Therefore, I may not acknowledge you when we meet in a public place, and I must decline to attend your family's gatherings if you invite me. Lastly, when our therapy is completed, I will not be able to be a friend to you like your other friends.

In sum, my duty as therapist is to care for you and my other clients, but only in the professional role of therapist.

My signature acknowledges that I understand the limits of the therapy relationship and agree to abide by those limitations.

Signature of client (or person acting for client)

Date

Printed name