Breakthrough Care and Resource Center

Adult Intake Form

Today's Date: _____

General Information

Name: _____ Birth date/Age: _____/_____

Address: _____

_____

Phone: (H) _____ (W) _____

Cell Phone: _____ Other: _____

Messages may be left at ____ H ____ W ____ Cell _____ Other

E-Mail Address _____

Use email for scheduling? ___Y General Information? ___Y Other _____? ___Y

Check Current Status:

_____ Married (Date of Marriage _____)
_____ Separated (Date of Separation _____)
_____ Divorced (Date of Divorce _____)
_____ Widowed (Since: _____)
_____ Never Married
_____ Other (Describe: _____)

Family Members (please list all adults and children living in the home)

Name	Birth date	Relationship	Describe relationship (not good, ok, good, etc.)

Present Employer/Occupation: _____/_____

Highest Level of Education: _____

Previous Mental Health Services for You or Family Members? Yes _____ No _____

Who: _____ Where: _____ Year: _____

Who referred you to this practice?: _____

Title/Relationship to you: _____

Medical Information

Do you have a family physician? Yes _____ No _____

Name of Physician: _____

Address: _____

Date last treated by physician: _____

Explain nature of the treatment and results: _____

_____

Any current medical problems? Yes _____ No _____

If yes, please explain the nature of the problem(s): _____

_____

Current medications (prescribed and over-the-counter). Please state name, how often taken, dosage, and purpose: _____

_____

_____

Please check any of the following which are now or have been a problem for you:

Mark Y or N	Symptom	Mark Y or N	Symptom
	High or prolonged fever		Vomiting
	Shortness of breath		High blood pressure
	Congestion		Menstrual problems

	Convulsions		Dizziness
	Low blood pressure		Vision problems
	Head injury		Headaches
	Unconsciousness		Soiling
	Ulcers		Stomach problems
	Diarrhea		Constipation
	Bedwetting		Tobacco Dependence
	Underweight		Other: _____
	Nightmares		Other: _____
	Insomnia		Other: _____
	Epilepsy		Other: _____

Comments/Explanations (if needed): _____

_____

Allergies? _____ No _____ Yes Details _____

_____

Family health mental history (blood relatives only). Please check any of the following that have occurred in your family (including yourself) and identify which family member(s):

Mark Y or N	Challenge	Family Member(s)
	Autism Spectrum Disorder	
	Alcoholism	
	Anxiety Disorder	
	Attention Deficit Disorder or Hyperactivity	
	Brain Injury	
	Bipolar Disorder	
	Depression	
	Drug Abuse	
	Eating Disorder	
	Learning Disabilities	
	Mental Retardation Personality Disorder (e.g., Borderline Personality DIsorder) Psychiatric Hospitalization	
	Schizophrenia Self-harming Behaviors Suicide (Attempted or completed) Other: _____	
	Other: _____	

Do you have or have you had a problem with drugs or alcohol?

Yes _____ No _____

If yes, please state which substances: _____

_____

List any major illnesses, injuries, and/or surgeries you have had (include age at the time):

_____

_____

None: _____

Have you ever been a victim of physical, sexual, or emotional abuse?:

Yes _____ No _____

Please list any past or current stressors or life events that you feel have caused problems for you or that have been difficult to overcome:

_____

_____

_____

Please use this space to share anything else you would like for me to know:

_____

_____

_____

_____