Meagan M. DiVito, Psy.D., P.C.

Adult Intake Form

Name: _____ Date: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Others living in the home:_____

PRESENTING PROBLEM

What brought you in today?

Please indicate symptoms/behaviors that you find problematic: (please circle)

Distractibility
Change in appetite
Suspicion/paranoia
Hyperactivity
Lack of motivation
Racing thoughts
Impulsivity
Withdrawal from people
Excessive energy
Boredom
Anxiety/worry
Wide mood swings
Poor memory/confusion
Panic attacks
Sleep problems
Seasonal mood changes
Fear away from home
Nightmares
Sadness/depression
Social discomfort
Eating problems
Loss of pleasure/interest
Obsessive thoughts
Irritability/Anger
Sexual Problems
Loneliness
Homicidal thoughts
Relationship problems
Low self-worth
Flashbacks
Work/School Problems
Guilt/Shame
Hearing Voices
Alcohol/Drug Use
Fatigue
Visual Hallucinations
Recurring/disturbing memories
Crying spells
Parenting problems
Frequent arguments
Self-harm behaviors
Problems with pornography
Aggression/fights
Thoughts of death
Computer addiction
Compulsive behavior
Hopelessness
Gambling
Other

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Are your problems affecting any of the following? (Please circle)

Handling everyday tasks
Self esteem
Relationships
Hygiene
Work/School
Housing
Health
Sexual Activity
Recreational Activities
Finances
Legal Matters

Have you ever had thoughts, made statements, or attempted to hurt yourself? Yes/No If yes, please describe (when and what happened):

Have you ever had thoughts, made statements, or attempted to hurt someone else? Yes/No If yes, please describe (when and what happened):

Have you recently been physically hurt or threatened by someone else? Yes/No If yes, please describe (when and what happened):

Treatment Goals:

From your preceding list of concerns, what do you want to see change FIRST and how much must they change for you to be satisfied?

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FAMILY/DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Legal Guardian			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
ADHD	
Autism	
Depression	
Bipolar Disorder	
Suicide	
Anxiety	
Panic Attacks	
OCD	
Developmental Disability	
Learning Disorder	
Sexually Abused	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

Please circle if you have experienced any of the following types of trauma or loss:

Emotional abuse
Neglect
Lived in a foster home
Sexual/Physical abuse
Violence in the home

Financial problems
Placed child for adoption
Teen pregnancy
Loss of a loved one
Parent illness

Multiple family moves
Parent Substance abuse
Crime victim
Homelessness
Other

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PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Reason for Treatment
		Outpatient Counseling		
		Medication (past and current)		

Yes	No	Type of Treatment	When?	Reason for Treatment
		Psychiatric Hospitalization		
		Drug/Alcohol Treatment		
		Self-Help/Support Groups		

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (circle all that apply):
Family
Neighbors
Friends
Students
Co-workers
Support/Self-Help Group
Community Group
Religious/Spiritual Center (which one?) _____

To which cultural or ethnic group do you belong?

If you are experiencing any difficulties due to cultural or ethnic issues, please describe:

How important are spiritual matters to you?
Not at all Little Somewhat Very much

LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement?

Is your child currently the subject of a custody case? Yes/No

Has your child ever been a ward of the court with DCFS guardianship? Yes/No

Do you or your child have any legal offenses on record or pending in the courts?