The Oak Inside
CENTER FOR PSYCHOLOGICAL ASSESSMENT & COUNSELING

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817-492-5105 • www.drjaquiotto.com

Date: _____

INTAKE FORM- Adult

Please complete this form to the best of your knowledge. Please write N/A for questions that are not applicable.

DEMOGRAPHIC INFORMATION

Client's Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Gender: _____ Ethnicity: _____
mm/dd/yyyy

Address: _____ City: _____

State: _____ Zip:_____

Home Phone_____ Consent to leave a detailed voice message here? ◉ **Yes** ○ **No**

Cell Phone_____ Consent to leave a detailed voice message here? ○ **Yes** ○ **No**
Consent to send text appointment reminders here? ○ **Yes** ○ **No**

Primary Email_____ Consent to send email appointment reminders? ○ **Yes** ○ **No**

Person completing this form (Choose one): **Client** ○ **Parent** ○ **Guardian** ○

Marital status: ○ **Single** ○ **Dating** ○ **Married** ○ **Separated** ○ **Divorced** ○ **Widowed**

List all people living in the household with the client:

Name:	Age:	Male/Female	Relationship to Child:
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	

List immediate family members living outside the home:

Name:	Age:	Male/Female	Relationship to Child:
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	

Please check all that apply for the last 12 months:

☐Family moved	☐Job change	☐Separation/divorce
☐Conflict in family	☐Death in family	☐Family financial problems
☐Changed school/ employment	☐New baby at home	☐Family accident or illness
☐Other: _____		

Please add any comments regarding the items noted above:

PRESENTING PROBLEM

What is your main reason for seeking counseling/assessment now:

How long has it been a concern? _____ When did this concern arise? _____

What seems to make the problem better?

What seems to make the problem worse?

What do you believe to be the major cause of the problem?

MENTAL HEALTH HISTORY AND PREVIOUS SERVICES

Please check all the client has received or is currently receiving:

☐ Psychoeducational testing	☐ ABA therapy
☐ Speech-language evaluation	☐ Social skills intervention
☐ Occupational/physical evaluation	☐ Counseling/therapy
☐ Neurological evaluation	☐ Family therapy/Parenting classes
☐ Genetic testing	☐ Speech/Language therapy
☐ MRI/EEG:	☐ Occupational/Physical therapy
☐ Neuropsychological evaluation	☐ Psychiatric hospitalization
☐ Psychiatric evaluation	☐ Other: _____

Please provide information regarding where and when these services occurred ****bring copies of reports to intake session:**

Is there a history of emotional trauma or extremely upsetting event? Please explain:

Is there a history of or current thoughts of self-harm or suicidal thoughts, threats, or attempts? Please explain:

Is there a history of or current thoughts, threats, or attempts to hurt another person? Please explain:

Is there a history of hospitalization for psychiatric reasons? Please explain:

List any previous or current mental health diagnoses:

HEALTH HISTORY AND WELLNESS

Are there any physical/medical issues *in the past* (accidents, injuries, surgeries, loss of consciousness)?

Do you have any current health/medical concerns?

List current medications:

Medication:	Dosage:	Reason:

Response to medications (positive and negative effects):

List any medications taken in past, dosage, and reason for medications:

Experiencing any problems with sleep?

Are there any *current or past* concerns regarding food, eating, exercise, weight or body image?

Are there any problems or worries about sexual functioning?

Last vision exam date: _____ Results: _____

Last hearing exam date: _____ Results: _____

Do you regularly use alcohol? If yes, how many drinks per week? _____

In a typical month, how often do you have 4 or more alcoholic drinks in a 24 hour period?

☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Do you think your alcohol use is a problem? _____

Have you used any substance in the past 30 days that was not prescribed by a doctor (e.g., marijuana, meth, MDMA, cocaine, Xanax or other benzodiazepine, Adderall or other stimulants, LSD, or other hallucinogens, heroin or other narcotics)? If yes, please indicate substances:

How often do you engage in recreational substance use?

☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Have you ever received treatment for alcohol and/or substance abuse or addiction? If yes, please indicate when, where and for which substance(s):

Have you experienced any of the following:

Domestic Violence?	○ **Yes** ○ **No**
Past or present Abuse or neglect?	○ **Yes** ○ **No**
Involvement with Department of Family Services?	○ **Yes** ○ **No**
Victim of a crime?	○ **Yes** ⊙ **No**

Please explain any 'Yes' response:

Have any **family members** been identified with the following condition(s):

Condition: Family Member

☐ Learning Problems:	☐ Dyslexia:
☐ Depression or sadness:	☐ Alcoholism/Drug Abuse:
☐ Anxiety Disorder:	☐ Bipolar Disorder:
☐ Autism Spectrum Disorder:	☐ Attention Deficits:
☐ Suicide/Suicide attempt:	☐ Schizophrenia:
☐ Tourette Syndrome:	☐ Cognitive Impairment:

EDUCATION AND EMPLOYMENT HISTORY

Highest level of education: _____

Experienced any learning problems in the past? Please explain:

Any behavioral or emotional challenges during school years? Please explain:

Career Plans (If still pursing education):

Current Employer: _____ Length of Employment: _____

Previous Employer: _____ Reason for Leaving: _____

Previous Employer: _____ Reason for Leaving: _____

Additional employment information (If any):

Please check any that apply:

Speech and Language: Do you/ Does the client:

☐ Have difficulty listening to verbal information	☐ Misunderstand verbal directions
☐ Confuse speech sounds	☐ Misunderstand Jokes, sarcasm, or idioms
☐ Mispronounce words	☐ Exhibit slow or halting speech
☐ Jumble up sounds in words	☐ Have difficulty expressing thoughts clearly
☐ Speak in a monotone or exaggerated manner	☐ Speak only to family members

Comments on questions above:

Behavior: Do you/Does the client exhibit the following:

☐ Self-injurious behavior: head banging or hair pulling	☐ Emotional outbursts
☐ Cries easily	☐ Physical aggression toward others or objects
☐ Frequent sadness or irritability	☐ Sudden mood changes
☐ Disinterest in participating in activities	☐ Excessive physical complaints
☐ Low frustration tolerance	☐ Avoid going to school or work
☐ Insists upon doing things a certain way	☐ Compulsive or ritualistic behavior(s)
☐ Difficulty making transitions between activities	☐ Repetitive movements: rocking or hand flapping
☐ Aversions to textures: List:	☐ Frequently argues with others
☐ Sensitivity to certain sounds List:	☐ Steals from others
☐ Fire setting	☐ Alcohol or drug use
☐ Dislikes being touched	☐ Engages in socially inappropriate behavior
☐ Engages in inappropriate sexual behavior	☐ Displays odd movements or habits
☐ Suspicious of others	☐ Socially isolates and withdraws from others
☐ Self-injurious behavior: Cutting	☐ Other:

Comments on questions above:

Social Skills:

☐ Trouble conversing with others	☐ Doesn't understand the body language of others
☐ Difficulty making eye contact	☐ Doesn't understand other's beliefs or intentions
☐ Trouble making and or maintaining friendships	☐ More interested in objects than people
☐ Overly trusting of others	☐ Excessively shy or timid
☐ Other:	

Comments on questions above:

Attention:

☐ Often tired during the day	☐ Inconsistent attention and focus
☐ Difficulty beginning or completing work	☐ Perform inconsistently in school
☐ Easily distracted	☐ Need instructions repeated
☐ Difficulty remembering recently learned info.	☐ Daydreams frequently
☐ Difficulty concentrating	☐ Act without thinking
☐ Miss parts of explanations and directions	☐ Difficulty staying on task
☐ Difficulty learning from mistakes/errors	☐ Trouble learning from consequences/rewards
☐ Has a messy room	☐ Frequently lose personal items
☐ Frequently procrastinates	☐ Loses or forgets to turn in completed work

☐ Doesn't write down/keep track of assignments	☐ Difficulty prioritizing work
☐ Difficulty planning for projects/tests?	☐ Difficulty completing work/tasks in a reasonable amount of time?
☐ Other:	

Comments on questions above:

Over the **last two weeks**, how often have you been bothered by any of the following problems?

Concern	Not at all	Several days in past two weeks	More than half the days in past two weeks	Nearly every day in past two weeks
Little interest or pleasure in doing things	○ 0	○ 1	○ 2	○ 3
Feeling down, depressed, or hopeless	○ 0	○ 1	○ 2	○ 3
Trouble falling or staying asleep, or sleeping too much	○ 0	○ 1	○ 2	○ 3
Poor Appetite or overeating	○ 0	○ 1	○ 2	○ 3
Feeling bad about yourself or feeling that you are a failure	○ 0	○ 1	○ 2	○ 3
Trouble concentrating on things, such as reading the newspaper or watching television	○ 0	○ 1	○ 2	○ 3
Moving or speaking so slowly that other people could have noticed. Or being the opposite, being so fidgety or restless that you have been moving around more than usual	○ 0	○ 1	○ 2	○ 3
Thoughts that you would be better off dead or of hurting yourself in some way	○ 0	○ 1	○ 2	○ 3

If you endorsed any of the above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not at all** ☐ **Somewhat Difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

Over the **last two weeks**, how often have you been bothered by any of the following problems?

Concern	Not at all	Several days in past two weeks	More than half the days in past two weeks	Nearly every day in past two weeks
Feeling nervous, anxious or on edge	○ 0	○ 1	○ 2	○ 3
Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
Worrying too much about different things	○ 0	○ 1	○ 2	○ 3
Trouble relaxing	○ 0	○ 1	○ 2	○ 3
Being so restless that it is hard to sit still	○ 0	○ 1	○ 2	○ 3
Becoming easily annoyed or irritable	○ 0	○ 1	○ 2	○ 3
Feeling afraid that something awful might happen	○ 0	○ 1	○ 2	○ 3

If you endorsed any of the above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not at all** ☐ **Somewhat Difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

Over the past **MONTH** have you been bothered by any of the following problems:

Had nightmares about or thought more than you wanted to about something that has happened to you that was intensely frightening, horrible, or upsetting?	◯YES	◯NO
Tried hard not to think about or went out of your way to avoid situations that reminded you of the traumatic event?	◯YES	◯NO
Were constantly on guard, watchful, or easily startled?	◯YES	◯NO
Felt numb or detached from others, activities, or your surroundings?	◯YES	◯NO

ADDITIONAL INFORMATION:

Thank you for taking the time to fill out this questionnaire. Please add any additional information you think is relevant or that you would like me to know:

_____
Signature of Person Completing Questionnaire

_____
Relationship to Client

How did you find us?

☐Google Search
☐Psychology Today
☐www.drjaquiotto.com
☐Other: _____
☐Other website: _____
☐Referred by a friend
☐Referred by a professional: _____

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