glassman
NEUROPSYCHOLOGY
ASSOCIATES LLC

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Phone: (414) 444-9811

Date Completed:

Adult Intake Form

If you need additional space for your responses, please include further details on the last page of this intake form.

Name of Patient: Date of Birth:

Referred by:

Person completing form if not patient:

Relationship to patient:

Gender: Marital Status: Ethnicity:

Household Income Level (please select one):

☐ Below $22,000 ☐ $22-44,000 ☐ $44-78,000 ☐ Above $78,000

Describe what issue or concern led to this appointment:

When did you first notice this problem?

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before (include any psychological testing completed as well)?

☐ Yes ☐ No

If yes:

Name of therapist:	
Dates of Treatment :	
Reason for seeking help:	

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Dates of Treatment :	
Reason for seeking help:	

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Dates of Treatment :	
Reason for seeking help:	

Describe any other treatment you have tried for this or any other psychological/psychiatric issue in the past: (When, where, why, was/is it helpful)

	When	Where	Why	Was it helpful
Medication (mental health)				
Psychiatric hospitalization				
AODA Treatment program				
Self-help/support groups				

Have you ever been the victim of abuse (emotional, sexual, or physical)? ☐ Yes ☐ No

If yes, please indicate your age at the time of abuse, the type of abuse experienced:

Have you ever perpetrated abuse or been the offender of abuse? ☐ Yes ☐ No

If yes, please indicate your age at the time of abuse, the type of abuse perpetrated:

Please check any of the following symptoms or complaints that you have experienced in the last 6 months. Indicate how long you have been experiencing these symptoms, and the frequency of the symptom (ie. Daily, More days than not, Weekly, Monthly):

✓		**For how long?**	**Frequency of symptom?**
	Sad or depressed mood		
	Low energy/fatigue		
	Hopelessness		
	Worthlessness		
	Crying spells		
	Guilt		
	Decreased motivation		
	Loss of interest in usual activities		
	Irritability		
	Hyperactivity		
	Impulsiveness		
	Elevated mood		
	Racing thoughts		
	Concentration or memory difficulties		
	Increased/decreased interest in sex		
	Increased/decreased appetite		
	Difficulty falling asleep		
	Difficulty staying asleep		
	Excessive sleeping		
	Suicidal thoughts or actions		
	Self-harm behaviors		
	Thought of harming others		
	Anxious/ worried		
	Panic attacks		
	Fear of leaving the house		
	Fear of driving		
	Fear of specific things or situations		
	Repetitive thoughts or behaviors		
	Upsetting, intrusive thoughts		
	Periods of "lost time"		
	Excessively orderly/perfectionistic		
	Difficulty trusting others		
	Binging or purging behaviors		
	Rebellious or defiant behavior		

Childhood/Adolescence

How would you describe your childhood/adolescence?

Did you experience any significant stressors during your childhood/adolescence (ie. accidents, hospitalizations, separation from family, divorce, etc)?

Family Mental Health History

Please list the individuals in your immediate family (ie. mother, father, grandparents, siblings)

Name	Relationship to you	Age	Quality of relationship

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Family history of:		Family member w/ history:
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Hyperactivity	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Autism Spectrum Disorder	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Self-harm Behaviors	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	
Death by suicide	☐ Yes ☐ No	
Psychiatric hospitalization	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

Substance Use History

Please provide the following information related to substances you currently use or have used in the past:

Substance	Age @ First Use	Use Last 30 Days	Average Quantity Per Use	Last Used	Amount Used
Alcohol					
Sedatives/Barbiturates					
Heroin (Opioids)					
Cocaine					
Other Stimulants					
Marijuana					
Hallucinogenic					

Have you ever passed out from drinking/drug use? ☐ Yes ☐ No

If yes, how often?

Have you ever blacked out from drinking/drug use? ☐ Yes ☐ No

If yes, how often?

Have you ever had the "shakes" or other withdrawal symptoms? ☐ Yes ☐ No

If yes, how often?

Have you ever felt you should cut down on your drinking/drug use? ☐ Yes ☐ No

If yes, how often?

Have people annoyed you by criticizing your drinking/drug use? ☐ Yes ☐ No

If yes, how often?

Have you ever felt bad or guilty about your drinking/drug use? ☐ Yes ☐ No

If yes, how often?

Have you ever drank/used drugs to calm yourself or relieve a hangover? ☐ Yes ☐ No

If yes, how often?

Do you use tobacco? ☐ Yes ☐ No

If yes, how often?

Medical History

Month/year of last physical exam:

Name of Physician:

Do you have any chronic medical conditions? ☐ Yes ☐ No

If yes, please list:

Do you have any CURRENT health concerns? ☐ Yes ☐ No

Please check and comment as necessary:

☐ BP:

☐ Diabetes:

☐ Thyroid:

☐ Heart:

☐ Lungs:

☐ Kidney:

☐ Stomach:

☐ Seizures:

☐ Headaches:

☐ Other:

Current prescription medications:

Medication	Dosage	Date First Prescribed	Prescribed by

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

Do you have allergies and/or adverse reactions to medications?

If yes, please list.

Education and Employment

Highest level of education completed:

While in school did you ever receive additional assistance or special education services?

☐ Yes ☐ No; If yes, please describe.

Were you ever diagnosed with a learning disability? ☐ Yes ☐ No

If yes, please describe.

Are you currently enrolled in a school or training program? ☐ Yes ☐ No

If yes, please list.

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

Do you enjoy your work?

Is there anything stressful about your current work?

Legal History

Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No

If yes, please explain.

Are you currently involved in any divorce or child custody proceedings? ☐ Yes ☐ No

If yes, please explain.

Do you have any pending legal charges? ☐ Yes ☐ No

If yes, please explain.

Are the services you are seeking here court ordered? ☐ Yes ☐ No

If yes, please explain.

If receiving assessment services, do you plan on using the testing report in legal proceedings? ☐ Yes ☐ No

If yes, please explain.

Social Information/ History

Who currently lives in your residence (adults and children)?

	Name	Relationship to you	Age	Quality of relationship
1				
2				
3				
4				
5				

If you have children, please list their names and ages.

	Name	Age	Sex		Name	Age	Sex
1				4			
2				5			
3				6			

Do you have challenges finding support (from family, friends, etc.)? ☐ Yes ☐ No

If yes, please describe.

Are you experiencing any difficulties or concerns due to race, culture, sexual orientation, gender, gender identity, age or ethnic issues? ☐ Yes ☐ No

If yes, please describe.

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

List any special areas of interest or hobbies (art, books, physical fitness, etc.).

If coming for therapy services, what would you like to accomplish out of your time in therapy?

If coming for assessment services, what do you hope to get out of your psychological or neuropsychological assessment?

Additional information: