CONNECTIONS THERAPY CENTER

Adult Intake

Dr. Cindy Stear, PsyD and Associates
815-957-0115
drcindystear@connectionstherapycenter.com

Marital Status: ◯ *single* ◯ *engaged* ◯ *married* ◯ *remarried* ◯ *separated* ◯ *divorced* ◯ *widowed*

Sexual Orientation (optional): _____*Gender Identification (optional):*_____

Presenting Problem - Describe your primary concerns: _____

_____

_____

Please indicate the severity of your problem on a scale from 0-10. Zero is mild and ten is very severe.

◯ *0* ◯ *1* ◯ *2* ◯ *3* ◯ *4* ◯ *5* ◯ *6* ◯ *7* ◯ *8* ◯ *9* ◯ *10*

FAMILY DATA:

Does your spouse or romantic partner live with you? ◯ *Yes* ◯ *No*

Name: _____ *Age:* _____ *Occupation:* _____

Describe your relationship with your spouse or romantic partner: _____

_____

Children: list the name, sex, age.

1. _____ *2.* _____ *3.* _____

4. _____ *5.* _____ *6.* _____

Describe your relationship with your children? _____

_____

*List anyone else who lives with you?*_____

_____

Father: living or deceased If deceased, age at death _____ *Cause of death* _____

Occupation? _____ *If living, present age* _____ *Health:*_____

Describe your relationship with your father? _____

_____

Mother: Living or deceased If deceased, age at death _____ *Cause of death* _____

Occupation? _____ *If living, present age* _____ *Health:* _____

Describe your relationship with your mother? _____

_____

Siblings: # of brothers? _____ *Ages:* _____ *# of sisters?* _____ *Ages:* _____

Describe your relationships with your siblings? _____

_____

How were you disciplined as a child? _____

Languages spoken in your home: _____

Does any member of your family have a past or present history of chronic illness? _____

*Is there any history of genetic disorders in the family?*_____

Has any family member had a language or speech problem? _____

Has any family member experienced emotional problems? ◯*Yes* ◯*No* *Committed suicide?* ◯*Yes* ◯*No*

_____

Has any family member experienced problems with alcohol or drugs? _____

Has any family member been hospitalized for psychological reasons? _____

EDUCATIONAL HISTORY

Highest grade completed: _____ *Last school:* _____ *Did you repeat any grade?* ◯*Yes* ◯*No*

Highest degree attained: ◯*GED* ◯*HS diploma* ◯*Associate's* ◯*Bachelor's* ◯*Master's* ◯*Doctorate*

Did you receive any special services inside or outside of school? ◯*Yes* ◯*No* *Describe:*

_____

_____

Were you ever placed on probation, suspended, or expelled from school? ◯*Yes* ◯*No*

Please explain _____

Best Subjects? _____ *Grades in these subjects?* _____

Worst subjects? _____ *Grades in these subjects?* _____

MEDICAL HISTORY

Physician's name: _____ *Phone:* _____*Date of last physical?*_____

Height: ____ Weight: ____ Do you exercise? ◯ Yes ◯ No How Often? _____

Any recent weight gain or loss? ◯ Yes ◯ No _____

List illnesses, injuries, hospitalizations, or surgeries during childhood or adolescence: _____

_____

List illnesses, injuries, hospitalizations, or surgeries during adulthood: _____

_____

Have you ever had a head injury or been knocked unconscious? ◯ Yes ◯ No

List current medications: _____

_____

List current allergies or health problems:

_____

How many meals per day? _____ Any changes in eating habit? _____

How many hours do you sleep at night? _____ Any changes in sleeping habit? _____

Do you drink alcohol? _____ How often? _____ How much? _____

Do you use drugs? Yes No How often? _____ How much? _____

Have you had a psychological or psychiatric evaluation? Yes No Explain: _____

_____

Have you ever been in counseling? Yes No Was it helpful? _____

Have you ever taken medication for psychological problems? Yes No Types:

OCCUPATIONAL HISTORY

Employer: _____Job Title: _____ How long? _____

Address: _____

Are you satisfied with your present work? Why? _____

What are your career goals? _____

Have you ever been fired from a job? Yes No Please explain: _____

_____

What kind of jobs have you had in the past? _____

SOCIAL HISTORY

Religion (optional) a) in childhood: _____ b) as an adult: _____

How many friends do you have that you can count on or confide in? _____

Do you have problems making or keeping friends? ◯ Yes ◯ No Explain:_____

_____

Have you ever been bullied or severely teased? ◯ Yes ◯ No Explain: _____

_____

When you were a child, did anyone ever touch you in a sexual manner? ◯ Yes ◯ No

Who? _____ How old were you? _____ How many times did it happen? _____

Have you ever been physically assaulted or beaten up? ◯ Yes ◯ No

By whom? _____ How old were you? _____ How many times did it happen? _____

Have you ever been forced to have sex against your will? ◯ Yes ◯ No

By whom? _____ How old were you? _____ How many times did it happen? _____

Have you ever had an experience where you were afraid for your safety or the safety of someone close to you?

Yes ◯ No ◯ Explain: _____

Have you ever been in trouble with the law? Yes No Explain: _____

_____

What are your hobbies and interests? _____

_____

Additional information you feel your therapist should know:_____

_____

_____

TREATMENT PLAN

Name: _____

Diagnosis : _____

_____

_____

Plan:

A. Goals

1. _____
2. _____
3. _____

B. Planned Interventions (must address goals set above).

1. _____
2. _____
3. _____

C. Objective Outcome Criteria (by which goal achievement is measured).

1. _____
2. _____
3. _____

_____ _____

Client or Legal Representative Date

_____ _____

Therapist Signature Date

_____ copy provided to client