Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, Glencoe & Litchfield

925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

Adult Intake

Date:_____ Name:_____ Home Phone:_____

Address:_____

Okay to leave messages/reminder calls?_____ Date of birth:_____

Age:_____ Race/Ethnicity:_____

FAMILY INFORMATION

Marital Status:_____ Emergency Contact:_____ Phone:_____

Child(ren)'s Name Age Sex Address

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Primary Care Physician/Clinic:_____

Address:_____

Phone:_____ Date of last exam:_____

List major health problems/disabilities/hospitalizations:_____

_____

List all current prescribed medicines with dosages and reason for taking:_____

_____

_____

List any known allergies to drugs or medicines:_____

_____

List any over-the-counter or herbal medicines used regularly: _____

_____

List any medications used previously for emotional problems:_____

_____

Were they helpful?_____

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EDUCATION/EMPLOYMENT INFORMATION

Highest Grade Completed:_____ Occupation:_____

Current School/Employment Status:_____

Military Service (date and branch):_____

MAIN PROBLEM

Brief description of main problem for which you are seeking help:_____

_____

How long has it been a problem?_____

_____

What previous mental health treatment has been tried - Was it helpful?_____

_____

_____

Previous mental health provider(s) with address/phone (if known):_____

_____

_____

What major stresses or changes have occurred in your life?_____

_____

_____

Include moves, job loss or changes, divorce, illnesses, deaths, trauma, legal problems, abuse issues, or alcoholism in family. Also mention major stresses for other family members, such as accidents, illnesses, job loss, etc.

Are you currently experiencing thoughts of hurting self or others? Yes/no

If yes, describe:_____

_____

Other concerns/comments:_____

_____

CHEMICAL HEALTH INFORMATION

Have you or others ever thought the following were a problem for you:

Alcohol? Yes/no _____

Cigarettes? Yes/no_____

Caffeine? Yes/no_____

Other drugs? Yes/no_____

Gambling? Yes/no_____

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Has previous chemical dependency/gambling treatment been tried and was it helpful?_____

_____

Treatment facility with address/phone (if known):_____

_____

Other family members use of alcohol, caffeine, or other drugs:_____

_____

SYMPTOM OR PROBLEM LIST

Please check each symptom or problem that applies for you:

	Yes	No		Yes	No
Depression or Sadness	___	___	Disoriented or Confused	___	___
Loss of Interest in Daily Things	___	___	Personality Changes	___	___
Sleep Problems or Nightmares	___	___	Hallucinations	___	___
Appetite Changes	___	___	Short Attention Span/Distractible	___	___
Irritable or Short Tempered	___	___	Impulsive	___	___
Withdrawn	___	___	Cannot Sit Still	___	___
Fatigue or Low Energy	___	___	Defiance	___	___
Guilty Feelings	___	___	Binging, Purging or Eating Concerns	___	___
Change in Activity Level	___	___	Excessive Concern with Appearance	___	___
Physical Complaints	___	___	Aggression	___	___
Self-Harming Behaviors	___	___	Legal Problems	___	___
Mood Swings	___	___	Other Dangerous Behaviors	___	___
Nervousness/Anxiety	___	___	Family Problems	___	___
Anxiety or Panic Attacks	___	___	Social Problems	___	___
Stressed	___	___	Sexual Behaviors or Problems	___	___
Fears	___	___	Work or School Problems	___	___
Obsessions/Compulsions	___	___	Negative Thoughts	___	___
Financial Problems	___	___	Speaking Noticeably Fast or Slow	___	___
Thoughts of Wanting to Die	___	___	Language/Communication Concerns	___	___
Chemical Use	___	___	Ticks	___	___
Cognitive Rigidity	___	___	Body Image/Perception Issues	___	___
Sensory Issues	___	___	Hypervigilance	___	___
Repetitive Thoughts/Behaviors	___	___	Racing Thoughts	___	___
Intrusive Memories	___	___	Nightmares/Flashbacks	___	___
Avoidance of Triggers	___	___	Psychosomatic	___	___
Low Self Esteem	___	___	Dissociation	___	___

Signature:_____ Date:_____