Huron Valley Consultation Center
Ann Arbor, Michigan

Date _____ Case # _____

ADULT INTAKE INFORMATION

Name _____ Home Phone _____ Business Phone _____

Cell phone/other phone _____ Email _____

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Sex _____ Marital Status: Single □ Married □ Divorced □ Widowed □ Living with partner □

Age _____ Driver's License # _____

Referred by:_____

In Case of emergency, contact (Name, relationship and phone number):

PLEASE CIRCLE FORM OF PAYMENT: CASH INSURANCE

Primary Insurance _____ Policyholder's Name _____ Relationship _____ Policyholder DOB _____

Contract Number _____ Group Number _____ Policyholder's Employer _____

Secondary Insurance _____ Policyholder's Name _____ Relationship _____ Policyholder DOB _____

Contract Number _____ Group Number _____ Policyholder's Employer _____

****FOR STAFF USE ONLY****

**DSM-V/ICD-10 _____ Code _____

Therapist Signature _____ Therapist Code _____

Print Name:_____

Insurance	Deductible	Copay	Yearly maximum	Lifetime max
Primary				
Secondary				

If applicable:
Authorization #:_____Number of sessions:_____Dates covered:_____

Rev. 2/2018

What are your reasons for seeking treatment at this time?

Have you seen a mental health or substance abuse professional (psychiatrist, psychologist, or social worker) in the past? If yes, explain.

Have you ever taken medications for a mental health, emotional problem, or substance abuse problem? If yes, explain.

Have you attended any self-help groups? If so, explain.

Family Information

Spouse's name Spouse's Date of Birth Spouse's Occupation

Children's Name(s), age(s), sex. Specify if child lives at home. Previous marriage(s) and children.

List significant extended family members. (Parent, brothers and sisters, etc.)

Explain any family history of physical illness or significant hospitalizations.

Explain any family history of mental or emotional illnesses, psychiatric hospitalization, history of suicide.

Any family history of substance abuse? Who was that? What substance(s) was abused?

Please describe any spiritual/religious/cultural affiliations.

Are social supports adequate at present? (Family, friends, co-workers)

Occupational/Educational History

Current employer and your job title

General satisfaction with your job

List past jobs and any comments:

Are you satisfied with your overall financial status? If not, explain.

Highest grade completed:

Describe your school performance:

Do you have any future plans for education? If yes, describe.

Leisure Activities

List some of your hobbies, activities, and talents.

With whom do you spend most of your free time?

Medical History

Name and address of your primary care physician

Height:_____ Weight:_____

When was your last physical exam?

Do you have any allergies, including food allergies? If yes, explain.

List all prescribed medications you are taking. Include dosage and frequency.

List all over-the-counter (including vitamins, minerals, diet pills, supplements, herbs, and other "natural" remedies) you are taking.

Have you ever had a problem with overuse of prescribed medications? If yes, explain.

Describe any surgeries, serious accidents, or hospital admissions.

Indicate whether you have had any of the following illnesses/symptoms.

	Now		Ever			Now		Ever	
	Yes	No	Yes	No		Yes	No	Yes	No
Anemia					High blood pressure				
Arthritis					Immune problems				
Asthma					Kidney disease				
Cancer					Paralysis				

	Now		Ever			Now		Ever	
	Yes	No	Yes	No		Yes	No	Yes	No
Dental problems					Prostate problems				
Diabetes					Seizures, epilepsy				
Earaches, infections					STDs				
Emphysema					Sleep problems				
Fainting/dizziness					Stroke				
Excessive fatigue					Thyroid disease				
Headaches					Ulcers (GI)				
Head injury					Urinary infections				
Heart problems					Vision/hearing problems				
Hepatitis					Other:				

Do you have physical pain? Yes_____No_____

If yes, rate the intensity of the pain: 1(mild) to 5 (severe): _____.

If yes, where is the pain located: _____.

If yes, how does it impact your functioning?

_____

Do you drink coffee, tea, cola, or consume other food, beverages, or medicines with caffeine? If so, please describe how much per day?

_____

Please provide information on your use of non-medical drugs.

Substance	**Used within 48 hrs.?**	**How often used?**	**Year first used?**	**When last used?**
Cigarettes/tobacco				
Alcohol				
Sleeping pills				
Marijuana				
Inhalants				
Cocaine/crack				
Heroin				
Other:				

Military History

Branch	Rank	Time in service	Active combat

Legal History

_____

Do you have any pending or prior legal problems? If yes, explain.

_____

Other:

Is there anything else you think we ought to know about you or you would like to tell us?

_____

Patient Signature:_____Date:_____

For therapist use only:

If it has been over a year since the patient's last physical, did you suggest that he/she have a physical? Yes_____No_____ Did the patient agree to this? Yes_____ No_____

Therapist/MD signature:_____Date:_____

Revised 2/2018

Adult Symptom Checklist

Name:_____**Age:**_____**Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each word or phrase, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

During the past **TWO (2) WEEKS,** how often have you been bothered by:	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Sleep disturbance	0	1	2	3	4
Trouble falling asleep	0	1	2	3	4
Interrupted sleep	0	1	2	3	4
Early morning wakening	0	1	2	3	4
Oversleeping	0	1	2	3	4
Loss of appetite	0	1	2	3	4
Overeating	0	1	2	3	4
Weight loss or gain	0	1	2	3	4
If so, how much in the last 3 months:					
Gained:_____Lost:_____					
Eating disorder	0	1	2	3	4
On the go, hard to relax	0	1	2	3	4
Mood swings	0	1	2	3	4
Racing thoughts	0	1	2	3	4
Hard to concentrate and stay focused on task	0	1	2	3	4
Periodic overspending	0	1	2	3	4
Gambling problem	0	1	2	3	4
Worry	0	1	2	3	4
Fears of ordinary things (for example, crowds, germs, doctors, flying, closed spaces)	0	1	2	3	4
Need for cleanliness	0	1	2	3	4
Need for organization	0	1	2	3	4
Counting behaviors/thoughts	0	1	2	3	4
Sexual difficulties	0	1	2	3	4
Relationship problems	0	1	2	3	4
Work problems	0	1	2	3	4
Yelling and screaming	0	1	2	3	4
Verbal, emotional, physical abuse/violence	0	1	2	3	4
Suspiciousness/paranoia	0	1	2	3	4
Feeling controlled	0	1	2	3	4
Trauma, other abuse	0	1	2	3	4

Suicidal thoughts, present	□ Yes	□ No
Suicidal thoughts, past	□ Yes	□ No
Suicide attempt or gesture	□ Yes	□ No
Homicidal thoughts	□ Yes	□ No

Approved 3/2018

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	