JESSICA LANG, LMFT

Adult Assessment

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Full Legal Name:_____

Preferred Name:_____

Gender (check all and any that apply):

I consider myself: □Male □Female □Transgender Male □Transgender Female □Other_____

[Transgender means a person whose gender identity is different from the gender assigned at birth]

Sexual Orientation:
I consider myself: □Straight/Heterosexual □Bisexual □Gay □Lesbian □Other_____

Preferred Pronoun (you may check more than one box): □He □She □They □Ze

Birth Date: _____ **Today's Date** _____

Address: _____

Home Phone: _____ May I leave a message? □Yes □No
Cell Phone:_____ May I leave a message? □Yes □No
Work Phone: _____ May I leave a message? □Yes □No

Referral Source?_____
Marital Status:
□ Single □Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed
Have Children:
□ Yes □ No □ Pregnant with First

Adult Intake Form

1. Presenting Problem/Issue (Please describe the main difficulty that has brought you to see me)

2. Are you currently taking any prescription medication?

□ No □ Yes: Please list Names & Purpose:_____

_____

3. List of Symptoms: Please circle any of the following that have been bothering you within the past 3 months:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt

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headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

4. Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

A) Marriage / Relationship:
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

B) Family:
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

C) Job/school performance:
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

D) Friendships:
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

E) Financial situation:
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

F) **Physical health:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

G) **Anxiety level / nerves:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

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H) **Mood:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

I) **Eating habits:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

J) **Sleeping habits:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

K) **Sexual functioning:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

L) Alcohol / drug use:
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

M) **Ability to concentrate:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

N) **Ability to control anger:**
__N/A__No effect __Little effect__Some effect__Much effect__Significant effect

5. **Substance Use**

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs?
Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:_____

_____

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6. **Past Psychological/Psychiatric Treatment**

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner, concerns then and their reasons for terminating:

_____

_____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates:

_____

7. **Other:**

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms?

_____

_____

_____

Let's Take a look at your childhood:

A) How would you describe your childhood overall?

A) Poor
B) Average
C) Good
D) Exceptional
E) Explain:_____

_____

B) How would you describe your relationship with your parents?_____

_____

_____

C) Did one or both of your parents have any mental illness (Depression, PTSD, Bipolar

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Disorder, Psychosis/Schizophrenia, or Substance abuse)? _____

_____

_____

D) Did either of your parents have significant medical issues during your childhood that required intensive care such as hospitalization and/or home healthcare?

_____

_____

E) Did you experience Emotional Abuse?_____

_____

F) Did you Experience Sexual Abuse?_____

_____

_____

G) Did you experience Physical Abuse?_____

_____

_____

H) Did you Experience Neglect?_____

_____

_____

I) Did you witness Domestic Violence?_____

_____

_____

J) Did you live in poverty?_____

_____

_____

K) Where you connected to someone special as a child?_____

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_____

_____

L) Did you experience bullying as a child?_____

_____

_____

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