THREEFOLD CLINICAL CARE

ADULT INTAKE QUESTIONNAIRE

Name:		DOB:		Age:	
Gender:		Race/ethnicity/ancestry:			
Marital status:		Occupation:			
Reason for seeking services (motivation, need, problem, symptoms, issues, concerns):					
How long have you had these needs, symptoms, or issues?					
Have you had treatment for these issues in the past?			Yes ☐	No ☐	
Have you received inpatient mental health treatment?			Yes ☐	No ☐	
Briefly describe mental health treatment history (dates and name of facility/therapist):					
Have you had treatment for substance use?			Yes ☐	No ☐	
Briefly describe substance use treatment history (dates, name of facility/therapist, substance concern):					
Do you have a family history of mental health concerns or substance use? If so, please describe:					
Describe the impact of the current emotional or behavioral struggles on family, employment, and social life:					

Describe your strengths and unique qualities:	
Are you currently under the care of a physician or psychiatrist? If yes, please provide the following:	
Doctor's name:	
Address:	
Phone:	
Treatment for:	
Medications:	
Have you ever experienced an upsetting event or situation? (abuse, neglect, abandonment, bullying, loss of a loved one or pet, moving, surgery, pain) If you feel comfortable, please briefly describe below:	
Have you ever witnessed an upsetting event or situation? If you feel comfortable, please briefly describe below:	

Symptom Checklist					
Symptom	Current	Past	Symptom	Current	Past
Crying, sadness, depression	☐	☐	Temper outbursts, aggression	☐	☐
Loss of enjoyment in usual activities	☐	☐	Irritability, anger	☐	☐
Desire to die	☐	☐	Argues frequently	☐	☐
Easily distracted	☐	☐	Disobedience	☐	☐
Made suicidal gestures/attempts	☐	☐	Hallucinations	☐	☐
Worries more than others	☐	☐	Unusual fears or phobias	☐	☐
Panics	☐	☐	Anxious, nervous	☐	☐
Repeats unnecessary acts	☐	☐	Is overly concerned	☐	☐
Exhibits rituals, habits, superstitions	☐	☐	Twitches, unusual movements	☐	☐
Easts very little/fasts to lose weight	☐	☐	Gorges or binge eats	☐	☐
Sleep walking	☐	☐	Blames others for own mistakes	☐	☐
Withdrawn	☐	☐	Easily annoyed by others	☐	☐
Nightmares, night terrors	☐	☐	Low motivation	☐	☐
Low self-esteem	☐	☐	Disorientation	☐	☐
Wakes up very early	☐	☐	Vomits intentionally	☐	☐
Tiredness, fatigue	☐	☐	Injures self intentionally	☐	☐
Restless sleep, wakes frequently	☐	☐	Struggles with friendships	☐	☐
Trouble falling asleep	☐	☐	Feels shy around others	☐	☐
Excessive sleep	☐	☐	Grief or loss	☐	☐
Poor appetite	☐	☐	Feelings of worthlessness	☐	☐
Under or over weight	☐	☐	Chronic pain	☐	☐
Hyperactivity	☐	☐	Drug use	☐	☐
Frequently acts without thinking	☐	☐	Alcohol use	☐	☐
Does not complete tasks	☐	☐	Cigarette use	☐	☐
Headaches	☐	☐	Sexual problems	☐	☐
Easily distracted	☐	☐	Mood swings	☐	☐
Academic struggles	☐	☐	Ideas of harming others	☐	☐
Worries about money	☐	☐	Disorganized thoughts	☐	☐
Concerned about family members	☐	☐	Problems at work	☐	☐
Relationship problems	☐	☐	Feelings of hopelessness	☐	☐
Daydreams, fantasizes	☐	☐	Problems with the law	☐	☐
Additional symptoms not listed above:					

Family Stressors					
Stressor	Current	Past	Stressor	Current	Past
Marital struggles	☐	☐	Housing problems	☐	☐
Marital separation	☐	☐	Legal issues	☐	☐
Divorce	☐	☐	Death of a friend	☐	☐
Custody disputes	☐	☐	Death of a relative	☐	☐
Financial problems	☐	☐	Death of a pet	☐	☐
Job loss	☐	☐	Family illness	☐	☐
Partner using alcohol/drugs	☐	☐	Intimate partner violence	☐	☐
Additional stressors not listed above:					

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Medical History				
Condition	Yes	No	Age	Details
Serious infection	☐	☐		
Convulsions/seizures	☐	☐		
Head injury	☐	☐		
Other injuries	☐	☐		
Medical hospitalizations	☐	☐		
Surgeries	☐	☐		
Poisoning	☐	☐		
Allergies	☐	☐		
Asthma	☐	☐		
Complications from alcoholism	☐	☐		
Complications from drug use	☐	☐		
Sexual problems	☐	☐		
Other:				
Other:				
Other:				

Family Information			
List all of the people who currently live with you			
Name	Age	Relationship	Occupation/grade in school

Who are your supports? (friends, faith, clubs, etc.)

What are your goals for treatment?

_____

Client (print) Signature Date

_____

Provider (print) Signature Date