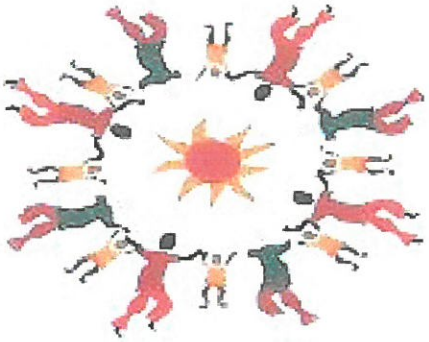

Full Circle Therapy
1500 McAndrews Road West,
Suite 230 Burnsville, MN 55337
Phone: 952-892-8404
Fax: 952-892-1722

Adult Intake

Name_____ **Age**_____ **DOB**_____
Today's Date_____ **Referred By**_____

CURRENT SITUATION

1. **Describe the concerns that led you to therapy.**

2. **What have you already done to try and help situation.**

3. **Describe what you hope to accomplish/change in therapy.**

4. **Name your strengths, interests, and activities you enjoy.**

5. **Please list sources of community and personal support.**

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Living Situation

_____with spouse/partner/significant other
_____alone _____ with roommate_____with children
_____with parents _____other

Please list any family members or other persons currently living with you.

Name_____Age_____
Relationship_____Rel Status: good fair poor

Name_____Age_____
Relationship_____Rel Status: good fair poor

Name_____Age_____
Relationship_____Rel Status: good fair poor

Name_____Age_____
Relationship_____Rel Status: good fair poor

Other significant family members not living with you

Name_____Age_____
Relationship_____Rel Status: good fair poor

Name_____Age_____
Relationship_____Rel Status: good fair poor

Name_____Age_____
Relationship_____Rel Status: good fair poor

Occupation/Student_____
Highest Level of Education_____

Have you been in jail, prison or juvenile detention? Yes No
If yes, please describe_____
Have you been arrested or convicted without above? Yes No

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Risk Concerns

1. **Do you currently have suicidal thoughts?** **Yes No**
   If yes, do you have a plan? **Yes No**
   If yes, what is the plan?_____

2. **Have you had suicidal thoughts in the past?** **Yes No**

3. **Have you attempted suicide?** **Yes No**
   If yes, when and how did you attempt?_____
   _____

4. **Do you drink alcohol?** **Yes No**
   If so, how often?_____
   How much on each occasion?_____

5. **Do you use illegal drugs** **Yes No**
   If so, what and how often?_____

6. **Have you used illegal drugs in the past?** **Yes No**
   If so, what have you used?_____

7. **Have you abused prescription medications?** **Yes No**
   If so, what medications?_____

8. **Do you or anyone close to you worry about your drinking or drug use? Yes No** **Treatment? Yes No**
   Where and when?_____

9. **Do you worry about anyone close to you and their substance use? Yes No** **Whom?**_____

10. **Do you have a history of physical, sexual, or emotional abuse?** **Yes No**
    Which type, year and by whom?_____

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MENTAL HEALTH HISTORY

Name of therapist_____

Current_____**previous: from**_____**to**_____

Name of Psychiatrist_____

Current_____**previous:from**_____**to**_____

Medication

Current_____

Previous_____

Ever hospitalized for mental health treatment? **Yes No**

When and where ?_____

MEDICAL HISTORY

Do you have a primary doctor? **Yes No**

Name_____

Date of last exam?_____

Do you have allergies? Describe_____

Do you exercise regularly? **Yes No**

Are you having sleep problems? **Yes No**

If so, please describe_____

Any current medical problems? **Yes No**

If so, please describe_____

ADDITIONAL INFORMATION (optional)

Religion/Spirituality_____

Race/Ethnicity_____

Any other information you'd like me to know?_____

_____

_____