ADULT Integrated Intake Assessment Form

This form is a confidential screening to assist you in informing your provider or treatment team about your presenting problem and treatment needs. A complete evaluation is necessary to establish a diagnosis. You may be asked more questions about some of these items to pinpoint problems or symptoms you may be experiencing. Please answer each question to the best of your ability in the space provided. *If you get triggered by a question, you may skip this question and discuss the section or trigger with your provider.* Thank you for choosing and trusting us.

1. Demographic Information: Please describe the following areas and feel free to expand in any way that will help us better understand you:

Ethnicity & Race:

Small input field

Legal Gender & Gender Identification:

Small input field

Sexual Orienation:

Small input field

Relationship Status/Orientation (i.e. single/partnered, monogamous/polyamorous) & children (ages):

Small input field

2. Presenting Concerns: What are your presenting problems? What brings you here?

Large input field

3. Treatment Goals: What are your goals of treatment? What do you want to work on?

Large Input field

4. SYMPTOMS LIST: Check off any of the symptoms below that have been bothersome or have occurred frequently during the LAST 6 WEEKS (please check all that apply):

- ☐ Violent Behavior
- ☐ Agitation
- ☐ Insomnia and/or trouble sleeping
- ☐ Decrease in sex drive
- ☐ Trouble making decisions
- ☐ Sad/depressed, down in the dumps
- ☐ Lack of/loss of interest in things
- ☐ Helpless feelings
- ☐ Fatigue- lack of energy
- ☐ Increase or decrease in appetite
- ☐ Binging or purging
- ☐ Restricting food or dieting
- ☐ Increase or decrease in weight
- ☐ Frequent crying or weeping
- ☐ Frequent thoughts of death or suicide
- ☐ Worthless feelings
- ☐ Excessive feelings of guilt
- ☐ Hopeless feelings
- ☐ Feeling life is not worth living
- ☐ Sleeping too much
- ☐ Difficulty falling asleep and/or staying asleep
- ☐ Frequent negative thinking
- ☐ Repetitive thoughts
- ☐ Repetitive behaviors
- ☐ Racing thoughts
- ☐ Constant worry
- ☐ Irritability
- ☐ Tense
- ☐ Easily fatigued
- ☐ Restlessness
- ☐ Keyed up, on edge
- ☐ Nervousness
- ☐ Trouble concentrating
- ☐ Fainting or feeling faint
- ☐ Tremors, trembling or shakiness
- ☐ Feeling in dreamlike state
- ☐ Fearful feelings
- ☐ Fear of losing control
- ☐ Palpitations
- ☐ Numbness or tingling
- ☐ Shortness of breath
- ☐ Sweating
- ☐ Dizziness, lightheadedness
- ☐ Fear of dying
- ☐ Jumpiness
- ☐ Memory problems
- ☐ Fear of doing something uncontrollable
- ☐ Intrusive thoughts
- ☐ Seeing or hearing things that are not there
- ☐ Fear of going crazy
- ☐ Strong bodily reactions
- ☐ Intrusive dreams
- ☐ Hyperactivity
- ☐ Decreased attention span
- ☐ Distractible
- ☐ Poor impulse control
- ☐ Problem with starting/finishing tasks
- ☐ Poor frustration tolerance
- ☐ Problems with accepting limits
- ☐ Poor school performance
- ☐ Poor work performance
- ☐ Poor concentration
- ☐ Anger
- ☐ Aggression
- ☐ Problem with following directions
- ☐ Poor cooperativeness
- ☐ Defiant
- ☐ Loses temper
- ☐ Financial problems

What are your top 5-10 concerning symptoms (current or recent past)?

Large Input field

5. Mental Health Care: Please list current and past Providers, Dates and Types of Treatment (i.e. Inpatient or Outpatient, Substance Abuse Treatment, etc.):

Large Input field

6. Trauma History: Please describe any current or past personal, emotional, physical, or sexual abuse (i.e. age and type of abuse):

Input field

7. Safety: Are you or have you ever experienced Suicidal/Homicidal Ideation and/or attempts? Please check all that apply

- ☐ Present - no plan
- ☐ Present - with plan
- ☐ Past history
- ☐ None

Please explain:

Input field

Any current risk of domestic violence, elder, child, or spousal abuse?

Input field

8. Medications: Please list medications currently prescribed and/or taking. Do you feel like they are working and if so which one(s)?

Large Input field

9. Medical:

Do you have any Allergies (i.e. medications, products, foods)? If so, please describe what kind and reaction:

Input field

Please describe any surgeries and/or medical devices (i.e. Bypass, C-Pap, Pacemaker, etc.):

Input field

Do you have any history of Head trauma/injury? If so, please explain (i.e. age/location):

Input field

Do you have any Medical conditions (i.e. history of seizures, heart attack, stroke, cancer)? Please describe:

Input field

8. Lifestyle Habits/Routines:

How many hours of physical activity do you have each week? Please describe type and frequency - i.e. daily 20 minute walk:

Large Input field

What is your average screen time per day (i.e. television, social media, computer/internet)?

Large Input field

Please describe your nutrition habits and relationship with food (i.e. mediterranean diet/2-3 meals day, track macros/calories with app, eat anything and everything):

Large Input field

Do you have a Meditation practice and if so what does it look like (i.e.never, yoga 2x week, 15 minute breathing meditation daily)

Small Input field

What are your passions, strengths, interests, hobbies?

Large Input field

Please describe your Caffeine Use (i.e. coffee, tea, soda) & frequency:

Small Input field

Please describe Alcohol Use (i.e. beer, wine, liquor) & frequency:

Small Input field

Please describe Nicotine Use (e.g. vapes, tobacco, cigarettes) & frequency:

Small Input field

Please describe Hallucinogens Use (e.g. Marijuana, LSD, “magic mushrooms”) & frequency:

Small Input field

Please describe Stimulants Use (e.g. cocaine, ecstasy) & frequency:

Small Input field

Please describe Opiate Use (e.g. heroin, oxycodone) & frequency:

Small Input field

8. Family:

Please describe your family of origin (i.e. where did you grow up, how long have you been on Maui, what was it like growing up in your family, who raised you, do you have siblings, any family history of mental health or substance abuse challenges, any history of neglect or abuse in your family, etc.):

Large Input field

Please describe any family or relationship challenges, needs, goals, and/or desires:

Input field

9. Education & Employment: Provide highest education achieved, any academic issues, and/or difficulties faced in school, career paths, currently employed/retired/disabled/full-time student/unemployed

Input field

10. Legal: Please describe current or past substance abuse, occupational, family, custodial or financial related legal problems:

Input field