# 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:

Legal Gender & Gender Identification:

Sexual Orientation:

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

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

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

**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)?

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

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

**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:

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

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

**9. Medical:**

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

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

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

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

**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:

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

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):

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)?

What are your passions, strengths, interests, hobbies?

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

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

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

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

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

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

**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.):

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

**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

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