HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

2740 South Jones Blvd, Las Vegas, NV 89146
Phone (702) 248-8866 / (800) 441-4483
Fax (702) 248-1339 / (866) 766-7652
www.hbinetwork.com

ADULT INTAKE-ASSESSMENT

Today's Date:________________________

Full Name:	Date of Birth: mm / dd / yyyy	Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Separated ☐ Divorced (No. of times________) ☐ Widow/er ☐ Cohabitating ☐ Never Married

Total number of people living in your household:	Ages of children:

Highest Education Completed: ☐ Primary ☐ High School/GED ☐ Some college ☐ Bachelor's Degree ☐ MA/MS ☐ PhD ☐ Other

Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Homemaker ☐ Student Type of work/position:

Ethnic Origin:	Religion:	Practicing/Active? ☐ Yes ☐ No

Do you need any cultural or language assistance? ☐ Yes ☐ No Please specify:

What is the reason for your visit today?

What symptoms do you notice?

When did the problem first start?

List the clinicians (and their phone numbers) you have seen for this condition. *No one will be contacted without your permission.*

List any medications you have taken for this current problem

Current Medications	Dose	Frequency	For how long?	Prescribing MD

List any/all allergies: ☐ None

Please indicate if you have a family history of any of the following conditions. (Check all that apply)

	Mother's Side	Father's Side		Mother's Side	Father's Side
☐ Seizure disorder	☐	☐	☐ Hyperactivity	☐	☐
☐ Neurological disorder	☐	☐	☐ Motor or vocal tics	☐	☐
☐ Attention or concentration problems	☐	☐	☐ Restlessness or fidgeting	☐	☐
☐ Mental Retardation	☐	☐	☐ Motor incoordination	☐	☐
☐ Drug or alcohol abuse	☐	☐	☐ Serious medical illness	☐	☐
☐ Depression or mania	☐	☐	☐ Cancer	☐	☐
☐ Anxieties, fears, or phobias	☐	☐	☐ HIV / AIDS	☐	☐
☐ Psychosis or schizophrenia	☐	☐	☐ Relationship problems/issues	☐	☐
☐ Psychiatric hospitalization	☐	☐	☐ Divorce	☐	☐
☐ Suicide/suicide attempts	☐	☐	☐ Domestic violence	☐	☐
☐ Homicide	☐	☐	☐ Sexual abuse	☐	☐

© 2007 Human Behavior Institute, Inc. All rights reserved. Adult-Intake-Assessment v1.4.2011

Check any of the terms that describe you when you were growing up:					☐ None
☐ Selfish	☐ Stealing	☐ Inattentive	☐ Arguing	☐ Distractible	☐ Sad
☐ Defiant	☐ Hurt Animals	☐ Fidgety	☐ Willful	☐ Restless	☐ Sickly
☐ Set Fires	☐ Destructive	☐ Anti-authority	☐ Call out in class	☐ Abusive	☐ Anxious
☐ Lack Conscience	☐ Lying	☐ Fighting	☐ Bully	☐ Cheating	☐ Looser
☐ Short attention	☐ Impulsive	☐ Risky Behaviors	☐ Can't wait for turn	☐ Hateful	☐ Bully
☐ Whining	☐ Demanding	☐ Irresponsible	☐ Disrespectful	☐ Uncaring	☐ Unattractive

MEDICAL PROBLEMS - List all past and present medical problems including surgeries or accidents. ☐ None

Medical condition	Age at onset

PSYCHIATRIC HOSPITALIZATION - List any hospitalizations you've had for psychiatric problems (whether it's for the current problem or other reasons). Use the other side of this page if more space is needed. ☐ None

When	Where	Why

OUTPATIENT TREATMENT - List any outpatient treatment you've had for the following: ☐ None

Problem	When	Where	Specific Reason
Mental Health			
Substance Abuse			
Gambling			

RECENT STRESSFUL LIFE EVENTS - Check all that apply among the following events that have occurred in the last 2 years. ☐ None

☐ Engaged	☐ Married	☐ Separated	☐ Divorced	☐ Death of spouse or other relation
☐ Pregnancy	☐ Retired	☐ Child left home	☐ Blended family	☐ Breakup of important relationship
☐ Moved/new home	☐ Foreclosure	☐ Major Illness	☐ Personal injury	☐ Bad health/behavior of a family member
☐ Unemployment	☐ Owe money	☐ Bankruptcy	☐ Legal problems	☐ Care for elderly/ill parent at home
☐ Other (please specify)				

Many of the following questions may not apply to you. Some may seem strange or even difficult to answer.
Just do your best to answer. Mark any/all statements below based on what you may have experienced. (*Check all that apply*)

While not on drugs, I remember experiencing the following. (Check all that apply) ☐ None

☐ I've had severe mood swings ☐ I've had bizarre or very unusual thoughts

☐ I've heard voices or sometimes talked to myself ☐ I've experienced seeing things/having visual hallucinations

Suicide ☐ Never	☐ I have thought about suicide.	If so, when was the last time?
	☐ I have attempted suicide.	If so, when and how?
Violence ☐ Never	☐ I've thought about hurting someone.	If so, when was the last time?
	☐ I've harmed/hurt someone else.	If so, when and how?
	☐ I'm thinking of hurting someone now.	If so, who?
Legal Matters ☐ Never	☐ I've been arrested.	If so, when/what reason?
	☐ I've been convicted of a felony.	If so, when/what reason?
	☐ I have a pending law suit.	Specify:
Smoking ☐ Never	☐ I have smoked/chewed tobacco.	If so, how many packs/day? For how long?

Patient Name:______________________________

Caffeine Drinks ☐ None

I drink this many cups of coffee per day	☐ 0	☐ 1	☐ 2	☐ 3	☐ More	☐ Not daily
I drink this many cups of tea per day	☐ 0	☐ 1	☐ 2	☐ 3	☐ More	☐ Not daily
I drink this many cans of soda per day	☐ 0	☐ 1	☐ 2	☐ 3	☐ More	☐ Not daily

Weight Change ☐ None

☐ I lost/gained weight more than 10 lbs. in the last 6 months. Current weight:__________ lbs. Height: _______ft. ______in.

Feminine Issues ☐ None

☐ I have irregular periods.
☐ I feel pain and discomfort when I'm on my period.
☐ I get moody, irritable, depressed, or irrational during my period.
☐ I've been pregnant _________ times.
☐ I've had ____________ miscarriages.
☐ I've had ____________ abortions.
☐ I have __________ living children.
☐ I take oral contraceptives.
☐ My contraceptives affect my mood.
☐ I am currently menopausal
☐ I am past menopause

Sexual Issues ☐ None

Male Difficulties: ☐ Partner ☐ Masturbation ☐ Lack of interest ☐ Erectile ☐ Ejaculation ☐ Premature ejaculation

Female Difficulties: ☐ Partner ☐ Masturbation ☐ Lack of interest ☐ No orgasm ☐ Feeling used ☐ Painful orgasm

Sadness and Depression ☐ None of the statements apply

☐ I go through periods of sadness or depression.
☐ I lose interest in everything.
☐ I have changes in appetite or lose/gain weight
☐ I have recurrent thoughts of death or suicide.
☐ These feelings come out of the blue.
☐ These thoughts/moods gotten worse over the last 2 weeks.
☐ I've had these moods constantly for at least one year.
☐ I have periods of low energy.
☐ I have periods of slowed activities or restlessness.
☐ I have difficulty falling asleep or oversleeping.
☐ These thoughts/moods come and go.
☐ They happen in reaction to bad things that happen.
☐ These thoughts/moods last and last.

Sleep ☐ None of the statements apply

☐ I tend to oversleep.
☐ I need regular naps.
☐ I have a hard time falling asleep.
☐ I have nightmares.
☐ I wake up short of breath or in a panic.
☐ I wake up with headaches.
☐ I wake up in the middle of the night or too early in the morning.

Anxiety or Fear

Answer these questions as they apply to your feelings or symptoms most days for the last 6 months.

☐ None of the statements apply

☐ I feel on edge, fearful or anxious.
☐ I get easily fatigued.
☐ I have difficulties concentrating or my mind goes blank.
☐ I feel irritable.
☐ I have muscle tension.
☐ I feel numb or like I'm outside my body.
☐ I have chills or hot flashes.
☐ I sometimes feel that things are not real?
☐ I sometimes feel like I'm going crazy or losing control.
☐ I have a fear of dying.
☐ My anxiety affects aspects of my life.
☐ I have trouble leaving my house, being in crowds or speaking in public.
☐ I have memories that are so real the event feels like it is really happening.
☐ I've had sleeping problems (falling or staying asleep).
☐ I worry excessively about things I find hard to control.
☐ When I'm nervous, I feel my heart race or miss beats.
☐ When I'm nervous, I feel shaky, sweaty or flushed.
☐ When I'm nervous, I have trouble breathing or swallowing.
☐ When I'm nervous, I feel chest pain or discomfort.
☐ When I'm nervous, I get nauseated or sick to my stomach.
☐ When I'm nervous, I get dizzy or feel faint?
☐ My anxiety comes in attacks and goes away just as fast.
☐ It always goes on all the time or ☐ only for a few days.
☐ I have unrealistic fears of people, places, or things.
☐ I frequently recall terrible events that have happened to me or that I have witnessed.

Emotional Well-Being ☐ None of the statements apply

☐ I've had weird body or facial movements.
☐ I feel I have to clear throat or nose sniffling often.
☐ My hands shake much of the time.
☐ Other parts of my body jerk or twitch uncontrollably.
☐ Other parts of my body jerk or twitch uncontrollably when I feel nervous.
☐ Other parts of my body jerk or twitch uncontrollably at night when I'm trying to sleep.
☐ I frequently eat more than normal amounts of food at one time.
☐ I take laxatives, make myself throw-up or exercise excessively to keep me from gaining weight
☐ I'm concerned about my sexual drive or behavior in some way.
☐ I'm concerned about some of my sexual habits that I think are unacceptable.
☐ I have been sexually abused.
☐ When I was growing up, I have witnessed or experienced physical abuse from caretaker(s).
☐ I've had blackouts, fits or seizures.
☐ I have fainted and then wet or soiled my clothes.
☐ I smell things that no one else smells, such as burnt rubber, urine, feces or old socks.
☐ I hear or see things that other people do not see or hear.
☐ I often have headaches.
☐ I frequently get lost or have problems with my memory.
☐ I have sensed that walls were breathing or objects were changing in size.
☐ I've had thoughts that just won't go away.

Patient Name:____

Emotional Well-Being ☐ None of the statements apply	☐ I do things over and over again almost unable to stop. ☐ I feel the urge to check my body often, lock the door over and over again, wash my hand, count or have everything just right. ☐ If I try to control these behaviors, I get uncomfortable or anxious. ☐ Others might describe me as rigid. ☐ I take things very seriously to the point that I have rituals, routines, or habits that don't seem to make any sense. ☐ I tend to treat others very poorly. ☐ I tend to act unusually rude, hostile or argumentative. ☐ I feel shame or regret later. ☐ I've gone several nights without sleep ☐ I've spent a lot of money ☐ I've used excessive amounts of drugs or alcohol ☐ I've given away things that I treasure ☐ I've felt lots of energy or powerful, exceptional or superior. ☐ I act or feel incredibly strong or smart. ☐ I've felt extremely jealous or envious. ☐ I've had times when I stopped taking care myself, such as bathing, shaving or getting dressed. ☐ Bizarre things have happened to me, like hearing voices, swearing or talking. ☐ The Radio or TV talked to me like some programs were directed especially for me. ☐ I've had thoughts or beliefs that others might find irrational or hard to believe. ☐ I seem to have more than a normal number of medical illnesses or conditions.
Gambling ☐ None of the statements apply	I gamble ☐ Everyday ☐ 2-3 times a week ☐ 4-5 times a week ☐ Weekends ☐ Occasionally When I gamble, I usually invest = $_______________________ The largest amount of money I've won = $______________ ☐ The more money gamble the more exciting it feels! ☐ I always think of ways increase my chances of winning. ☐ I think of when and where I'm going to gamble next. ☐ I'm restless/irritable when I try to cut down or stop gambling. ☐ I don't tell my spouse/others how much I *really* gamble. ☐ I always think of ways to get money so I can gamble. ☐ I tried but I can't control, cut back or stop gambling ☐ I gamble to feel better or as a way to escape problems. ☐ When I lose money gambling, I go back another day to get even. ☐ I've committed illegal acts in order to pay for gambling (i.e., passing bad checks or taking money that didn't belong to me, etc.) ☐ I have jeopardized or lost a significant relationship, job or education opportunity because of gambling. ☐ I have relied on others to provide money to relieve a desperate financial situation caused by gambling. Last time I've gambled was:________________________ How many years have I been gambling? ______________
Alcohol and Drug Use ☐ None of the statements apply	I drink alcohol ☐ Everyday ☐ 1-2 times a week ☐ 3-5 times a week ☐ Weekends ☐ Occasionally On an average day, I usually drink ☐ 1-2 shots/bottles of beer ☐ 3-6 shots/bottles of beer ☐ more than 6 shots/bottles of beer The most I've drank in a 24-hour period was: ☐ 1-2 shots/bottles of beer ☐ 3-6 shots/bottles of beer ☐ more than 6 shots/bottles of beer Last time I've had a drink was:________________________ How many years have I been drinking?________________ I have taken or experimented with the following substances: (Check all that apply) ☐ Marijuana ☐ Cocaine/crack ☐ Loritabs, Oxycontin, Vicodin, or other pain killers ☐ Heroin/Opiate ☐ LSD/Hallucinogens/PCP ☐ Inhalants, glue, paint, gasoline, aerosols ☐ Amphetamine/Speed ☐ Xanax, Valium, Ativan, etc. ☐ Other How frequent do I use drugs? ☐ Daily ☐ 1-2 times a week ☐ 3-5 times a week ☐ Weekends ☐ Occasionally Last time I've used drugs was:________________________ How many years have I been using?_________________ ☐ I've been told or felt that I should **c**ut down on my drinking or drug use. ☐ I've felt **a**nnoyed by people criticizing me about my drinking or drug use. ☐ I've felt bad or **g**uilty about my drinking/drug use. ☐ I have drank or used drugs first thing in the morning as an **e**ye-opener to steady my nerves or get rid of my hangover.

Give more details, if you can.

____

____

____

____

Patient Signature:_________________________________

Reviewed by **Clinician**:______________________________

Date:______________________________

Patient Name:____