ACTS Therapy LLC
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ADULT INTAKE

Name____Phone ____

HEALTH DATA

Your Physician (Full name) ____Phone ____

Address____City_______________________________State______Zip__________________

If you have any current medical problem please describe them and include any infectious diseases
____
____

Are your medical problems being treated? _____Y: _____N: If yes by whom? ____

Date of most recent physical: _______________________________

What medications are you're currently taking? ____

Have you ever had a drug allergy or sensitivity? _____Y: _____N: If yes to what drug? ___________________________________

Have you ever seen any of the following to help with a problem? Please check

Psychiatrist_____: Psychologist_____: Social worker_____: Counselor_____: Minister_____: Chemical Dependency Counselor_____: For what? ____When? ________________________________

Previous psychiatric or chemical dependency hospitalization? _____Y: _____N: If Yes Where? _______________When? ______

CHEMICAL USE INFORMATION

Do you drink alcoholic beverages? _____Y: _____N: If yes what do you drink ____beer: _____wine: _____hard liquor:
How often do you drink? _____daily: _____3-5 times weekly: _____1-2 times weekly: _____less frequently
Do you sometimes drink more than you planned? _____Y: _____N:
Have family and friends ever expressed concern about your drinking or drug use? _____Y: _____N: If yes which? ____________
Have you ever been arrested for alcohol or drug related charges: DVI, public intoxication etc.? _____Y: _____N:
Have you ever been treated for drinking or drug problems or gone to AA, NA etc? _____Y: _____N:
Have you ever had episodes where you were unable to remember periods when you were drinking? _____Y: _____N:
Have you ever overdosed? _____Y: _____N:
WHAT HAS BEEN YOUR EXPERIENCE WITH THE FOLLOWING?
Tranquilizers: Valium, Librium, Tranxene, Axene, Miltown, Equanil, Zanax? ____use currently: ____used in past: ____never used
Pain Pills/Narcotics: Darvon;Codein:Percodan;Demerol, Dilaudid, Heroin? ____use currently: ____used in past: ____never used
Stimulants: Amphetamines, Speed, Dexedrine, Ritalin, White Crosses, Sip, Cocaine and its derivatives ie, crack, crank
____use currently: ____used in past: ____never used
Sleeping Pills?Soporidics: Doriden, Placidyl, Dalmane, Seconal, Tuinal, Nembutal, Amytal, Phenobarbital, Noctec, Somnos
____use currently: ____used in past: ____never used
Hallucinogens: Marijuana, Hashish, THC, LSD, Mescaline, Psilocybin, MDA, PCP, Angel Dust, Mushrooms
____use currently: ____used in past: ____never used
Volatiles: Aerosols, Paint Thinner, Glue, Lacquer, Amyl or Butyl, Nitrate, "Poppers", Gasoline
____use currently: ____used in past: ____never used
Nicotine: Include cigarette, cigars, chew: ____use currently: and amount______: ____used in past: ____never used
FAMILY MEMBERS

Spouse or significant other: ___________________________________ age_______: emotional problems: _____Y: _____N:

Living: _____Y: _____N: Occupation ____

Mother's Name: ___________________________________ age_______: emotional problems: _____Y: _____N:

Living: _____Y: _____N: Occupation ____

Father's Name: __________________________________ age_______: emotional problems: _____Y: _____N:

Living: _____Y: _____N: Occupation ____

Stepmother's Name (if applicable): __________________________________ age_______: emotional problems: _____Y: _____N: Living: _____Y: _____N: Occupation ____

Stepfather's Name (if applicable): __________________________________ age_______: emotional problems: _____Y: _____N:

Living: _____Y: _____N: Occupation ____

Other significant person responsible for raising you: _________________________________ age_______: emotional Problems: _____Y: _____N: Living: _____Y: _____N: Occupation ____

Number of children of person completing form_____: Age of oldest _____: Age of youngest _____: # of deceased _____

Number of brothers & sisters _____: Age of oldest _____: Age of youngest _____: # of deceased _____

Number of other persons living in household and relationship ____

NOTIFY IN CASE OF EMERGENCY

Name ____Phone____

Address_____________________________________City____________________________State______Zip_________________