UNIVERSITY of MARYLAND CHILDREN'S HOSPITAL

The Care Clinic
520 W. Lombard St, Gray Hall, Ground Floor
Baltimore, MD 21201

Adult Intake Form

This information is needed to help us get to know you. Please answer all the questions that best that you can. Let us know if you have any questions. Thank you!

Name:	Birthdate/age:	Today's Date:
Who told you about the Care Clinic?		Phone:

Presenting Issues:

Trauma History: (mark all that apply)

☐ Physical abuse
☐ Neglect
☐ Accidents
☐ Community violence
☐ Sexual abuse
☐ Intimate partner violence
☐ Natural disasters
☐ Other: _____

Description: _____

_____

_____

_____

Other stressful life events: (mark all that apply)

☐ Divorce
☐ Job loss
☐ Poverty
☐ Grief/Loss
☐ homelessness
☐ other:_____

Description: _____

_____

_____

_____

Symptoms: (mark all that apply)

☐ Physical complaints
☐ Mood disturbance
☐ Nightmares
☐ Changes in appetites
☐ Aggression to others/property
☐ Suicidal ideation
☐ Substance abuse
☐ Risky sexual behaviors
☐ Anger/irritability
☐ Fear/worries/anxiety
☐ Sleep problems
☐ Flashbacks/intrusive thoughts or memories
☐ Self harm behaviors
☐ Problems with relationships/social skills
☐ Work problems
☐ other: _____

Describe including when they started, how long they have lasted, etc. _____

_____

_____

_____

_____

What copings skills and interests do you have (writing, drawing, talking, exercise, etc)? _____

What are your strengths and where do you get your support?_____

What are your goals for treatment?_____

Psychosocial History:

Where there any concerns during the pregnancy, your birth, or with your developmental milestones? If yes, explain. _____

What was the family situation at time of your birth _____

Describe your daily living activities (hygiene, exercise, ability to pay bills, get to work, etc)? _____

Sleep concerns: ☐ Trouble falling asleep ☐ Wakes up at night ☐ Nightmares
Describe:_____

Eating habits…_____ meals each day ☐ Snacks frequently
(#)
Any food allergies or other dietary concerns: _____

How is your health? ☐Excellent ☐ Good ☐ Poor: Explain:_____

Do you take any medications: ☐no ☐yes: list _____
List any significant illness or accidents that you have had: _____

Please list and describe any previous mental health treatment that you've received:

School history including highest degree earned, areas of study, and overall school experience (include any special education services you received): _____

_____

_____

Current (or most recent) job: _____Time at that job:_____
Still employed? ☐ Yes ☐No
Other job history (types of jobs, time spent at jobs, etc.):_____

_____

Describe any problems or successes:_____

_____

Relationship history including number of significant romantic relationships and average length and quality of relationships (please note if you married and/or lived with anyone and any domestic violence you may have experienced): _____

_____

_____

_____

How do you get along with the other people in your life (i.e. family of origin, friends, children, co-workers, etc)?_____

_____

_____

Do you have any history of legal involvement (this includes arrests, custody issues, etc)? ☐No ☐Yes
If yes, please explain _____

_____

_____

Substance use: Please fill in the table below

Substance	Types	Age of 1st use	Current use: amount & frequency	Problems or treatment because of use?
Alcohol				
Tobacco				
Illegal drugs				
Misuse of prescriptions				

List any other concerns that you may have: _____

_____

_____

_____

_____

_____

Family History:

Please list all the people who are close to you.

Name	Relationship to you	Age/DOB	Live with client?

Family medical history: _____
_____
_____
_____

Family psychiatric/substance abuse history: _____
_____
_____
_____

Family legal history: _____
_____
_____
_____

Other important family information: _____
_____
_____
_____

By signing below, you affirm that the above, to the best of your knowledge, is truthful and correct.

_____ _____
Signature Date