



Full Circle Therapy
2500 McAndrews Road #230
Burnsville, MN 55379
952-892-8404

ADULT INTAKE

Name _____ Age _____ DOB _____
Today's Date _____ Referred By _____

CURRENT SITUATION

1. Describe the concerns that led you to therapy.

2. What have you already done to try and help situation.

3. Describe what you hope to accomplish/change in therapy.

4. Name your strengths, interests, and activities you enjoy.

5. Please list sources of community and personal support.

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Living Situation

_____with spouse/partner/significant other
_____alone _____with roommate_____with children
_____with parents _____other

Please list any family members or other persons currently living with you.

Name _____ **Age** _____
Relationship _____ **Rel Status: good fair poor**

Name _____ **Age** _____
Relationship _____ **Rel Status: good fair poor**

Name _____ **Age** _____
Relationship _____ **Rel Status: good fair poor**

Name _____ **Age** _____
Relationship _____ **Rel Status: good fair poor**

Other significant family members not living with you

Name _____ **Age** _____
Relationship _____ **Rel Status: good fair poor**

Name _____ **Age** _____
Relationship _____ **Rel Status: good fair poor**

Name _____ **Age** _____
Relationship _____ **Rel Status: good fair poor**

Occupation/Student _____
Highest Level of Education _____

Have you been in jail, prison or juvenile detention? Yes No
If yes, please describe _____

Have you been arrested or convicted without above? Yes No

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Risk Concerns

- 1. Do you currently have suicidal thoughts?** **Yes No**
If yes, do you have a plan? **Yes No**
If yes, what is the plan? _____

- 2. Have you had suicidal thoughts in the past?** **Yes No**

- 3. Have you attempted suicide?** **Yes No**
If yes, when and how did you attempt? _____

- 4. Do you drink alcohol?** **Yes No**
If so, how often? _____
How much on each occasion? _____

- 5. Do you use illegal drugs** **Yes No**
If so, what and how often? _____

- 6. Have you used illegal drugs in the past?** **Yes No**
If so, what have you used? _____

- 7. Have you abused prescription medications?** **Yes No**
If so, what medications? _____

- 8. Do you or anyone close to you worry about your drinking or
drug use?** **Yes No** **Treatment? Yes No**
Where and when? _____

- 9. Do you worry about anyone close to you and their substance
use?** **Yes No** **Whom?** _____

- 10. Do you have a history of physical, sexual, or emotional
abuse?** **Yes No**
Which type, year and by whom? _____

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MENTAL HEALTH HISTORY

Name of therapist _____
Current _____ **previous: from** _____ **to** _____

Name of Psychiatrist _____
Current _____ **previous: from** _____ **to** _____

Medication
Current _____
Previous _____

Ever hospitalized for mental health treatment? **Yes** **No**
When and where ? _____

MEDICAL HISTORY

Do you have a primary doctor? **Yes** **No**
Name _____
Date of last exam? _____

Do you have allergies? Describe _____

Do you exercise regularly? **Yes** **No**

Are you having sleep problems? **Yes** **No**

If so, please describe _____

Any current medical problems? **Yes** **No**

If so, please describe _____

ADDITIONAL INFORMATION (optional)

Religion/Spirituality _____

Race/Ethnicity _____

Any other information you'd like me to know? _____

