Adult DBT Intake Form

Today's Date: ____________

Personal Information:

Name: ______________________________DOB: ____________ Age: ______ SS#________________

Address: ____City: ______________________

State: _______ Zip: ______________

Home Ph#___________________ Cell Ph#________________Email: _________________________

Years of School Completed: ___________ Ethnicity:_______________ Religion/Spiritual Belief:____________

Place of Employment: __________________________How long?:_______ Work Ph#______________________

Auto Year: ____________ Make: __________________Model: _________ License Plate#:_____________

Marital Status: _________________#of Marriages: ___________________# of children: ______________

Information about Spouse/Partner:

Name: _______________________DOB: ____________ Age: ______ SS#_____________________

Phone #:_______________________ Email: _______________________
Is this your Emergency Contact? Yes No (please complete below)

Emergency Contact Name: _________________________________Relationship: _____________________

Address: ____ Ph#: _____________________________

Please describe why you are currently seeking DBT counseling?

In your opinion, how severe is the problem:

_____ I don't think it is a problem, I'm here because someone else believes I should be.

_____ Mild _____ Moderate _____ Severe _____ Debilitating

How long do you believe you have struggled with this ? ___________

Which of the following has this problem affected?
_____ Performance at work _____ Relationships with family _____ Relationships with peers _____ Health

Client Name____________________________ Clinician Initials_____Date:_____________

Have you ever been treated by a counselor before? _____ Yes _____ No
If so, when and by whom?

Did you find it effective or helpful? _______Yes __________No.
If No, what didn't work for you?

Have you ever been hospitalized in a psychiatric facility? _____ Yes _____ No
If so, where and when?

Problem Behavior History

Have you had any thoughts/urges/actions related to the following (please check all that apply):
___ *Suicide* ___ *Self-Harm* ___ *Homicide* ___*Drug/Alcohol abuse*
___*Binging/purging*

If you answered yes to any of the above, please rate the intensity of the thoughts/urges and actions between 0 (no intensity) and 10 (high intensity)
Suicide:___ Self Harm___ Homicide____ Drug/Alcohol abuse_____ Binging/Purging____

Do you currently have any thoughts of suicide No_____ Yes _____
Do you have a history of any previous attempts?

Dates:______________

Have you ever been referred to a psychiatrist or your family doctor for an evaluation for psychiatric medications? __ No ___Yes Do you need a medication referral? ____No ___Yes Are you opposed to the use of medications? ___No ____Yes?
Are you interested in alternative treatments such as acupuncture, essential oils, yoga, massage? _____No _____Yes

Are you currently taking any medications? _____ Yes _____ No
If so, please list the medications and dosages:

Height: ______ Weight: _______ Date of last physical exam: ______________ Date of latest blood tests: _________
Personal physician/Psychiatrist (Name, Phone) _____________________________________

Medication Allergies? ___ No ___ Yes, which meds? _______________________________________ Food Allergies? ____No ____Yes ____

Please indicate your drug/alcohol use (if more than one, list in order of drug/alcohol of choice)

Type of drug/alcohol (be specific)	Amount Used	Frequency of Use	Date of Last Use

Client Name____________________________ Clinician Initials_____Date:_____________

How many cigarettes do you smoke a day? ______ None: ____ None, but used to: _______

Do you drink alcohol?
_____ No _____ Regularly (2-4 times a week) _____ Occasionally (less than 4 times a month)
_____ Daily

When you drink alcohol, how many drinks do you usually have?
_____ Does not apply _____ One or two _____ Three or four _____ Five to seven _____ More than 8

Do you use any illegal drugs?
_____ No ____ No, but did in the past _____ Occasionally _____ Regularly _____ Daily

Which of the following have you experienced as a result of your drug and/or alcohol use?
_____ None
_____ Missed work because of drinking and/or using
_____ Have been in physical fights because of drinking and/or using
_____ Have been arrested for an alcohol or drug related incident
(i.e. possession, assaulted while intoxicated, driving under the influence etc.)
_____ Have driven after drinking or using
_____ Have had an accident while driving intoxicated or under the influence of drugs and/or alcohol
_____ Lost driver's license because of drinking or using
_____ Had arguments with friends or relatives while drinking and/or using, or because of drinking and/or using

Body Issues

Has there been a recent change in your weight?
_____ No _____ Yes, increase _____ Yes, decrease
If so, how much have you gained/lost? Gained _____ Lost _____

To what do you attribute this weight loss or gain?

Has there been a recent change in your appetite?
If so, what?

How many times do you exercise each week?

When you exercise, how long do you exercise?

Have you ever intentionally thrown up?
_____ No _____ Yes, but not since ___/___/___ _____ Yes, currently _____ Number of times per day

Are you sexually active? _____ No _____ Yes

Have you ever been sexually abused? _____ No _____ Yes
If so, when and by whom?

Was the person prosecuted?

What problems do you have with sleep?

Client Name____________________________ Clinician Initials_____Date:_____________

_____ None _____ Trouble falling asleep _____ Wake up during the night
_____ Wake up too early _____ Don't feel rested after waking

How many hours of sleep do you get per night (average)?

Family Mental Health History:

Who primarily raised you?

Where were you raised?

Please list all of your siblings, ages and any known mental health diagnosis.

Name	Age	Mental health Issues
______________________	_____________	____
______________________	_____________	____
______________________	_____________	____

Which is true about your biological mother?
_____ I do not know if she is alive or deceased _____ She is alive and well _____ She is alive but in poor health _____ She is deceased

If still living, which is true about your relationship with your biological mother?
_____ I have no contact with her as a result of: _____ My decision _____ Her decision _____ I was adopted
_____ I have a distant relationship with her and we communicate:
_____ Weekly _____ Monthly _____ Yearly _____ None of the above
_____ I have a close relationship with her and we communicate:
_____ Daily _____ 3-5 times a week _____ Weekly _____ Monthly _____ Yearly

Describe any medical problems your mother has/had:

Describe any Interpersonal problems you and your mother have:

Which of the following is true about your biological father?
_____ I do not know if he is alive or deceased _____ He is alive and well _____ He is alive but in poor health
_____ He is deceased

If still living, which is true about your relationship with your biological father?
_____ I have no contact with him as a result of: _____ My decision _____ His decision _____ I was adopted
_____ I have a distant relationship with him and we communicate:
_____ Weekly _____ Monthly _____ Yearly _____ None of the above
_____ I have a close relationship with him and we communicate:
_____ Daily _____ 3-5 times a week _____ Weekly _____ Monthly _____ Yearly

Describe any medical problems your father has had:

Describe any Interpersonal problems you and your father have:

What is your current financial situation?

_____ Current on all bills _____ Slightly behind on a bill or two _____ Behind on all bills including rent/ mortgage
____ Considering filing for bankruptcy _____ Recently filed bankruptcy____

WELL-BEING QUESTIONNAIRE

Directions: On each of the five statements, circle which is closest to how you have felt over the ***last*** week. Note that higher numbers mean better well-being.

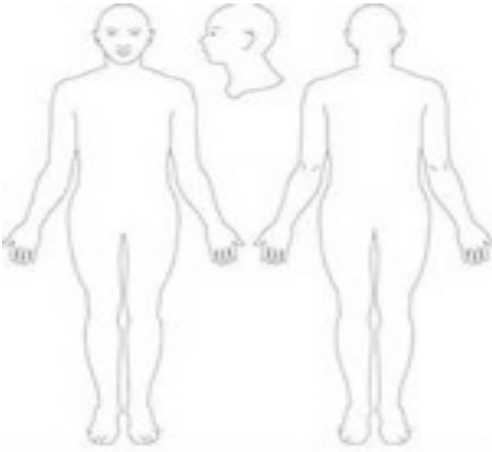
	All the time	**Most of the time**	**More than half the time**	**Less than half the time**	**Some of the time**	**At no time**
I feel cheerful and in good spirits	5	4	3	2	1	0
I feel calm and relaxed	5	4	3	2	1	0
I feel active and vigorous	5	4	3	2	1	0
I wake up feeling fresh and rested	5	4	3	2	1	0
My daily life is filled with things that interest me	5	4	3	2	1	0

TOTAL OF ABOVE: ____________

PAIN AND BODY CONCERN

Directions: On the diagrams below, please mark the areas where you are experiencing pain and/or concerns about your body. Please explain below:

Client Name_____________________________ Clinician Initials_____Date:_____________



Do you have medical problems? ___ No   ___Yes; explain:

____

Do you have any **children** with chronic health problems?   ____ No   _____ Yes; describe:

____

Do you have a hearing impairment of other physical disability? ____ No   ____ Yes; describe:

____

What are your goals for therapy?

Client Name_____________________________ Clinician Initials_____Date:_____________