

Adult Intake Form

Please fill out this form and bring to your first session. Information you provide is protected and confidential.

Name: _____
(First) (Middle Initial) (Last)

Name of parent or guardian (if under 18): _____
(First) (Middle initial) (Last)

Birthdate: ____ / ____ / ____ Gender: Male ____ Female ____

Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____ Domestic Partnership ____

Children/Age: _____

Address: _____
(Street name and number)

(City) (State) (Zip Code)

Contact Information:
Cell Phone: _____ Home Phone: _____

Email: _____ Other: _____

How can I confirm appointments: Email ____ Phone ____ Text ____

Emergency Contact Person: _____ Phone _____

Relationship to you: _____

Physician Name: _____ Phone: _____

Are you employed? Yes ____ No ____ If yes, current occupation _____

Have you ever seen a counselor before? Yes ____ No ____

If yes, describe your experience _____

General Health & Mental Health Information

1. Are you currently taking any prescription medications? Yes_____No_____
If Yes, please list:_____
2. Are you taking or have you previously been prescribed psychiatric medications?
Yes_____No_____ Please list and give dates:_____
3. Describe your current physical Health?_____
4. Describe your current sleeping habits_____
5. Do you exercise regularly? Yes_____No_____Type?
_____Frequency?_____
6. List what you do for fun, recreation or as a hobby?_____
7. What significant life changes or stressful events have you experienced recently?

8. What do you consider to be some of your strengths?_____
9. What is one thing that you feel is very important for me to know about you?

10. What is the nature of the problem for which you are seeking help?_____

Adult Personal History Questionnaire

Please circle any of the following that apply to you:

Alcohol Abuse

Anxiety

Child abuse

Childhood Trauma/Neglect

Compulsive Behaviors

Depression

Domestic Violence

Eating Disorders

Emotional Abuse

Grief

Job loss

Sexual Abuse

Substance Abuse

Suicide Attempts

Suicidal Thoughts

Other:_____

Family History

Who provided most of the parenting to you as a child? _____

Briefly describe the family and home in which you grew up? _____

Current Living Situation

Please describe your current living situation. Please include the first names of those with whom you live, their age and relationship to you. _____
