**Michael Fish, Ph.D., P.A.**

**Adult Client Intake Form**

Name of Client:________________ Today's Date:_______________
Address:_______________________________________________________________
_______________________________________________________________________
Phone Number(s): Home-( )_____________ Work( )_______________
Social Security No:___________________ Age:______
Date of Birth:__________ Occupation:_________________
Education:_________________________
Briefly Describe Your Reason For This Office Visit______________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Who Referred You to This Office, Or How Did You Hear About Dr.Fish?____________________________________________________________
When Were You Last Examined by a Physician?____________________
Name of Physician:___________________ Phone:___________________
List Any Major Health Problems for Which You Are Currently Receiving Treatment:________________________________________________
_______________________________________________________________________
List Any Medications You Are Now Taking:_________________________
_______________________________________________________________________
Have You Ever Received Psychiatric or Psychological Help or Counseling of Any Kind Before?_________ If You Have, Please Explain:_______________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Are You Currently Married?____, Separated?____, Divorced?____, Widowed?____. For How Many Years?_______ How Many Times Have You Been Married Including Your Present Marriage?___________
List The Members Of Your Family And All Others Who Are Living In Your Home:

| Name(s) | Age | Relationship | Occupation |
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Please Circle Any Of The Following Problems Which Pertain To You:

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|---|---|---|---|
| Nervousness | Energy | Alcohol Use | Nightmares |
| Shyness | Loneliness | Self-Control | Appetite |
| Separation | Education | Stress | Parenting |
| Drug Use | Temper | Headaches | Fears |
| Anger | Children | Memory | Suicidal |
| Sleep | Depression | Insomnia | Finances |
| Relaxation | Sexual Problems | Inferiority | Friends |
| Legal Matters | Divorce | Career Choice | Marriage |
| Mood Fluctuates | Abuse | Work Problems | Eating |