

INTAKE FORM: ADULT INDIVIDUAL

General Information:

Name: _____ Birth Date: _____

Address: _____

City: _____ Zip Code: _____

Cell Phone: _____ Other Phone (work, home): _____

May I leave a message? _____

E-mail Address: _____

In case of emergency, contact: _____
Name

_____ Address

_____ Phone Number Relationship

Relationship & Family Information:

Married _____ Domestic Partnership _____ Committed relationship _____
Single _____ Separated/Divorced _____ Widowed _____

Other (describe) _____

Length of current relationship: _____

Describe the quality of this relationship:

Poor _____ Fair _____ Good _____ Excellent _____

Please list children (any age): _____

Please list members of your household: _____

Mental Health Services & History

Have you received any kind of mental health services before? If yes, describe:

Type _____

Clinician/Agency _____

Dates: _____

Have you ever experienced any of the following:

Depression _____

Anxiety _____

Panic Attacks _____

Eating Disorders _____

Trauma/Abuse _____

Substance abuse/dependency _____

Domestic violence _____

Insomnia _____

Suicidal thoughts/attempts _____

Please explain any conditions checked above _____

General Health

Medical diagnoses or conditions: _____

Medications: _____

Describe your current physical health:

Poor _____ Fair _____ Good _____ Excellent _____

How many alcoholic beverages per week? _____ What kind of alcohol? _____

Do you engage in recreational drug use? _____ If yes, what drug(s) ? _____

Employment/Education

Highest level of education: _____

Profession & Current employer: _____

Describe your professional life:

Unsatisfying _____ Somewhat satisfying _____ Satisfying _____ Very satisfying _____

Reasons for seeking treatment

Please describe current challenges, stressors and reason for seeking therapy:

Please describe your goals and desired outcome for therapy:

Who referred you/ how did you find me:

Date completed: _____