Adult Intake Form

Client's name: ____ Date: _____/_____/______

Gender: ___F ___M ___Other Date of Birth: ____/____/____ Age: ________ SSN: _________________________

Form Completed by: ____ May I leave a voicemail? Y / N

Phone # (H) _____________________________ (C) _________________________________ May I text you? Y / N

Address: ____________________________________ City: _____________________ State: ______ Zip: ____________

Email address: ____May I email you? Y / N

Spouse/Significant Other's name: ____

Emergency Contact: ____ Relationship: __________________________

Phone (H): ____ (C): ____

Who referred you to this Program? Self Family Primary Doctor Therapist Insurance Website Friend

PERSONAL HISTORY

If you need any more space for any of the following questions, please use the back of the sheet.

Primary reason(s) for seeking services:

___Anger management ___Anxiety ___Coping ___Depression

___Eating Disorder ___Fear/Phobias ___Mental Confusion ___Sexual Concerns

___Sleeping problems ___Addictive behaviors ___Alcohol/drugs ___Hyperactivity

___Other mental health concerns (specify): ____

____

What are your goals for your therapy? ____

____

____

____

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FAMILY HEALTH HISTORY

Have any of the following diseases occurred among blood relatives? (Parents, siblings, aunts, uncles, or grandparents) Check those that apply:

___Allergies	___Cleft lips	___Kidney Disease	___Perceptual motor disorder
___Anemia	___Cleft Palate	___Mental Illness	___Seizures
___Asthma	___Deafness	___Migraines	___Spinal Bifida
___Bleeding tendency	___Diabetes	___Multiple Sclerosis	___Suicide
___Blindness	___Glandular problems	___Muscular Dystrophy	
___Cancer	___Heart Diseases	___Mental Retardation	
___Cerebral Palsy	___High Blood Pressure	___Nervousness	

___Other (specify): ____

____

Comments regarding Family Health: ____

____

HEALTH

List any current health concerns you may have: ____

____

List any recent health or physical changes: ____

____

Please check if there have been any recent changes in the following:

___Sleep patterns	___Eating patterns	___ Behavior	___ Energy level
___Physical activity level	___General disposition	___Weight	___Nervousness/tension

Describe changes in areas in which you checked above: ____

____

MEDICATIONS

Allergic to any medications or drugs? ___Yes ___No If yes, describe: ______________________________________

____

Current prescribed medications	Dose	Dates	Purpose	Side Effects
______________________________	_______	_______	__________	___________________________________
______________________________	_______	_______	__________	___________________________________
______________________________	_______	_______	__________	___________________________________

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CHEMICAL USE HISTORY

Do you use or have a problem with alcohol or drugs? ____ Yes ____ No If yes, describe: _________________________

____

FEELINGS ABOUT WORK

____Anxious	____Passive	____Enthusiastic	____Fearful
____Eager	____ No Expression	____Bored	____ Rebellious

____Other (describe): ____

____

COUNSELING/PRIOR TREATMENT HISTORY

Information about yourself (past and present):

	Yes	No	When	Where	Reaction to overall experience
Counseling/Psychiatric Treatment	____	____	______________	_____________	________________________________
Suicidal thoughts/attempts	____	____	______________	_____________	________________________________
Drug/Alcohol treatment	____	____	______________	_____________	________________________________
Hospitalization	____	____	______________	_____________	________________________________
Involvement with self-help	____	____	______________	_____________	________________________________
Groups (e.g. AA, AL-Anon, NA,	____	____	______________	_____________	________________________________
Overeaters Anonymous)	____	____	______________	_____________	________________________________

For Office Use Only

Therapist's comments: ____

____

____

Therapist's signature/credentials: _____________________________________ Date: ____/____/____

Supervisor's comments: ____

____

Physical exam: Not required

Supervisor's signature/credentials: ___________________________________ Date: ____/____/____

(Certifies case assignment, level of care)

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