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Adult Intake Form

Please answer the following questions to the best of your knowledge/ability.
All information provided is protected as confidential information

Name: _____ Social Security Number: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Marital Status: ☐ Never married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____
(street & number) (city) (state) (zip)

May I mail to you at this address? ☐ Yes ☐ No, please send mail to _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

May I contact you and leave messages at these numbers? ☐ Yes ☐ No, please contact me via _____

Email: _____ May I email you? ☐ Yes ☐ No
*please note: email correspondence is not considered to be a confidential medium of communication

Children (names and ages): _____

Current Employer: _____ Position: _____
Work Address: _____
Length of employment with this employer: _____ No. of years in this occupation: _____

GENERAL HEALTH INFORMATION:

Physician's Name: _____ Phone: ( ) _____

Address: _____ Last Appt: _____

Are you currently experiencing any health problems? ☐ No ☐ Yes
If yes, please describe: _____

Are you currently seeing a psychiatrist? ☐ No ☐ Yes
If yes, Name and Phone Number: _____

Are you taking any prescription medications? ☐ No ☐ Yes
If yes, please list: _____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes
If yes, please list name(s) and dates: _____

Have you previously received any type of mental health services (i.e., psychotherapy, psychiatric services, etc.)?
☐No ☐ Yes If yes, dates(s) & reason for treatment:_____

_____

Have you ever been hospitalized for emotional or mental reasons? ☐No ☐ Yes
If yes, please describe (i.e., dates, reasons, location: _____

_____

_____

How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

MENTAL HEALTH INFORMATION:

1. Are you currently experiencing overwhelming sadness, grief or depression?
☐No ☐Yes If yes, for approximately how long? _____

_____

2. Are you currently experiencing anxiety, panic attacks or have any phobias?
☐No ☐Yes If yes, describe type & when it began? _____

_____

3. Are you currently experiencing any chronic pain?
☐No ☐Yes If yes, please describe: _____

_____

4. Do you drink alcohol more than once a week? ☐No ☐Yes
If yes, quantity and how often _____

5. How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never
If yes, what type and how often _____

6. Are you currently in a romantic relationship? ☐No ☐Yes If yes, for how long? _____
On a scale of 1 to 10, how would you rate your relationship? _____

7. What significant life changes or stressful events have you experienced recently? _____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In this section below please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorder(s)	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior(s)	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts/Completion	Yes / No	

Family of Origin:

Mother ☐ alive ☐ deceased (date: _____) Father ☐ alive ☐ deceased (date: _____)
Siblings (age and gender): _____

How would you characterize or describe the relationships with your family of origin (i.e., with your parents, with your siblings)? _____

History of death within your circle of family and/or friends: _____

ADDITIONAL INFORMATION

1. What is your current employment situation: _____
   Do you enjoy your work? _____
   Is there anything stressful about your current work? _____
2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
   If yes, describe your faith or belief: _____
3. What do you consider to be some of your strengths? _____

4. What would you like to accomplish out of your time in therapy? _____

5. Do you have any specific fears or concerns with regard to your time in therapy? _____

6. How were you referred to me? _____

Person(s) to contact in case of emergency:

Name: _____ Phone Number: (____) _____ Relationship: _____

Name: _____ Phone Number: (____) _____ Relationship: _____