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Adult Intake

Today's Date _____ DOB: _____ Gender _____ Referral Source _____

Name: _____

Last First Middle (Nickname)

Address: _____ Phone: _____

Email:_____

Emergency Contact: _____ (name, relationship) Phone: _____

For Confidentiality, when and how do you prefer to be reached?_____

Ethnic/Race Origin: □ American/Alaska Native □ Asian □ Black or African American □ Hawaiian/Pacific

Islander □ Hispanic/Latino □ Non-Hispanic/Latino □ White □ other_____

Relationship Status: □ Single □ Married □ Cohabitant □ Separated □ Divorced □ Widowed □ Prefer not to answer

Insurance Information:

Company Name: _____

Phone: _____ ID#: _____ Group #_____

Auth #: _____ Approved dates of Service: _____

Approved # of Sessions:_____

Family History and Current Composition

_____

_____

_____

_____

_____

_____

What type of counseling are you seeking? Please select one:

__ INDIVIDUAL 1-on-1 counseling (1 intake form).

__ FAMILY 2 or more family members (1 intake form per person over 18 yrs. Old)

__ PRE-MARITAL Couples who are engaged or considering it (1 intake form per person)

__ MARITAL Couples needing marital guidance (1 intake form per person).

__ Group Counseling. Group Specified: _____ (1 intake form).

Presenting Issue:

_____

_____

_____

Goals for Treatment:

_____

_____

_____

Substance Abuse History and Treatment

_____

_____

Medical History and Current Status (Include hospitalizations, and any surgeries).

_____

_____

Psychiatric History (Include diagnosis, medication, dosage, prescriber, compliance, allergies).

_____

_____

_____

_____

Legal Issues:

_____

_____

_____

Suicidal or homicidal ideation, thoughts, attempts? None (include dates, method, and outcomes)

_____

_____

Eating or sleeping problems in the last 30 days? None _____

Level of Readiness for Treatment (scale 1-10, 10 being ready).

Any additional Information you would like to add, please use space below