Date: _____

Awakened Awareness, LLC

Adult Intake Information

Last Name	First Name	Middle Initial	Preferred Name

Race	Primary Language	Date of Birth	Age

Street Address

City	State	Zip Code

Home Phone ☐ Cell Phone ☐ Email Address ☐

(please check preferred method of contact)

Is it ok to leave messages? Yes ☐ No ☐

Gender Identity	Preferred Pronouns	Sexual Orientation

Administrative Sex:	Marital Status	Employment Status
☐ Male	☐ Married	☐ Employed
☐ Female	☐ Single	☐ Student
☐ Prefer Not to Answer	☐ Divorced	☐ Unemployed
	☐ Other _____	☐ Other _____

Previous treatment (individual therapy, inpatient admissions, PHP/IOP, etc.)?

Yes ☐ No ■ Duration: _____
Please provide additional information for all previous treatment. Was it helpful? Why or why not?

_____

_____

_____

_____

_____

Family members in your home (provide name, age, gender, and relationship):

_____

_____

_____

Emergency Contact (name, relationship, and contact number):

_____

Is it ok to leave messages? Yes ☐ No ☐

Intake Information

Presenting Problem/Concern (please include as many details as possible, including duration, areas of life affected, level of life interference):

_____

_____

_____

_____

_____

_____

Current Support System & Coping Skills:

_____

_____

_____

_____

Current Medical Conditions (please include all medications):

_____

_____

_____

Personal History of Alcohol/Substance Use:

_____

_____

_____

Personal History of Mental Illness:

_____

_____

_____

Suicide/Homicide (thoughts, frequency, intensity, duration, attempts & when):

_____

_____

_____

Family History of Alcohol/Substance Use, Mental Illness, Suicide/Homicide:

_____

_____

_____

_____

_____

Goals of Therapy:

_____

_____

_____

_____

_____

Personal Strengths:

_____

_____

_____

_____

Additional Information that you feel will be helpful. Thank you!

_____

_____

_____

_____

_____

_____

_____

I certify that the above information is true and correct to the best of my knowledge.

Signature of Client Date