TEXAS COUNSELING
Individual, Couples, Family
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ADULT INTAKE FORM

Date of First Session: Diagnosis:

Personal Data:

Date:

Name:

Address:

City: Zip:

Telephone number: (day) (evening)

Email:

Ok to leave message/text at above numbers? ☐Yes ☐No

DOB: Age: Occupation:

Who referred you?

With whom are you now living? (list people)

Where do you reside? ☐ house ☐ hotel ☐ room ☐ apartment ☐ other

Clinical Information:

What is happening in your life which resulted in this appointment?

Whom have you previously consulted about your present problem(s)?

Are you taking any medication? If “yes”, what, how much, and with what results?

What is there about your present behavior that you would like to change?

What feelings do you wish to alter (e.g., increase or decrease)?

What would you like to see accomplished in therapy? List at least 3 goals.

1.
2.
3.
4.
5.

Date of First Session: Diagnosis:

Name:

(First Name) (Middle Name) (Last Name)

Home Address:

(Street Address) (Apt)

(City) (State) (Zipcode)

Phones: Home Work

Cell Text ok? ☐

Preferred method of contact: Home ☐ Work ☐ Cell ☐

Email:

Patient Social Security Number: Gender:

Patient Date of Birth: Marital Status:

Employer:

Student Status (if attending school) Full-time ☐ Part-time ☐

Who recommended you to this office?