ADULT INTAKE FORM

Today's Date: _____

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ Cell/Other Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Place of Employment/School:_____

Marital Status: □ Never Married □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed

Name of Spouse/Partner:_____ Cell/Other Phone:_____

Please list any children/age: _____

Referred by: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If yes, previous therapist/practitioner: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Please list any specific health problems you are currently experiencing:

Please list any prescription medications and dosage that you are currently taking

Name of Prescribing Physician:_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:

Please list any specific sleep problems you are currently experiencing:

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

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

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

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:
Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Please list any legal issues that may be in progress:

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

Are you currently employed or in school? □ No □ Yes
If yes, what is your current situation? Do you enjoy your work? Is there anything stressful about your current work?

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

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

FAMILY MENTAL HEALTH HISTORY

In the section below 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 Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	