ADULT INTAKE FORM

NAME: ____ DATE: ___________

AGE: _________ DATE OF BIRTH: ____________________

HOME ADDRESS: ____

____

YOUR CELL PHONE:___________________ — ok to leave a message? Y/N

HOME PHONE: _______________________ — ok to leave a message? Y/N

EMAIL: _____________________________ — ok to leave a message? Y/N

HOW WOULD YOU LIKE ME TO CONTACT YOU? ___________________________

WORK (IF APPLICABLE): ____

IF YOU HAVE A PARTNER, NAME AND CONTACT INFORMATION:

____

____

PHYSICIAN'S NAME:____

PHYSICIAN'S PHONE NUMBER:____

MAY I CONTACT THEM? ____
(in order for me to do so, you will need to give your permission by signing a consent)

 CLIENT NAME:______________________________

ARE THERE ANY MEDICAL CONDITIONS I SHOULD KNOW ABOUT? __________

____

CURRENT MEDICATIONS:

NAME OF MEDICATION/ DOSE/ FREQUENCY

____

____

____

____

ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST? ______________

PSYCHIATRIST NAME (IF APPLICABLE): ___________________________________

PSYCHIATRISTS PHONE NUMBER (IF APPLICABLE): __________________________

MAY I CONTACT THEM? ____
(in order for me to do so, you will need to give your permission by signing a consent)

REFERRAL SOURCE (who referred you or how did you hear about practice):

____

CURRENT OR PREVIOUS COUNSELING, TREATMENT, AND/OR SUPPORT GROUP EXPERIENCE:

____

____

CLIENT NAME:______________________________

WHAT DID YOU LIKE AND NOT LIKE ABOUT PREVIOUS THERAPY EXPERIENCES:

____

____

____

____

ANY FAMILY OR PERSONAL HISTORY OF MENTAL ILLNESS, ALCOHOLISM, SUBSTANCE ABUSE, SUICIDAL THOUGHTS, OR SUICIDAL ATTEMPTS?

____

____

____

ARE YOU HAVING SUICIDAL THOUGHTS NOW? ____________________________

PLEASE DESCRIBE WHY YOU ARE SEEKING THERAPY: ______________________

____

____

ANYTHING ELSE YOU THINK I SHOULD KNOW OR YOU WOULD LIKE ME TO KNOW ABOUT YOU?

____

____

____

THANK YOU FOR PROVIDING THE ABOVE INFORMATION. PLEASE UPDATE ME IF YOUR ANSWERS CHANGE TO ANY OF THESE QUESTIONS.