ADULT INTAKE FORM

Name:____ Date: __________________

Street: ______________________________________ State: __________ Zip: ___________

City: _______________________________________ Email: ____________________________

Telephone: ___________________ Home, Cell, Work (*Please Circle*) Leave message Y/N

Email Address: _________________________ Date of Birth: _____________________

Employer: _____________________________ Occupation: _______________________

Marital Status *(Please Circle)*

Single Engaged Living Together Married Separated Divorced Widowed

Name of Spouse/Partner: ____

Names of Children	Age	Gender	Living w/ you?	Relationship To You
		M F	Y N	
		M F	Y N	
		M F	Y N	
		M F	Y N	

Who should be notified in case of emergency?

Name: ______________________________ Relationship: _____________________________

Best Telephone Number to Contact: ____

Authorization of Telephone Message: Y/N

Medication	Dosage	Began MM/YY	Symptoms	Prescribing Doctor

Current Physician(s) Monitoring Your Care		
Name of Physician	*Specialization*	*Length of Time*

Current Concerns:

What Brought You to Therapy

****Please List Distress Level: 1 some, 2 Moderate, 3 Quite a bit, 4 Extreme***

Concern	Length of Time	*Distress Level

Please provide the following information (Circle all that apply)

Gender
- Male
- Female
- Other

Sexual Orientation
- Heterosexual
- Gay/Lesbian
- Bisexual

Children
- No
- Yes, How Many

Employment Status
- Full Time
  - Occupation: _____________
- Part Time
  - Occupation: _____________
- Unemployed
- Student
- Retired
- Homemaker

Current Household Income
- Less than $60,000
- $61,000 to $80,000
- $81,000 to $99,000
- Over $100,000

Ethnic or Racial Origin
- American Indian/Alaska Native
- Asian
- African American/Black
- Caucasian/White
- Mexican-American/Hispanic
- Biracial:
- Other: ________________________

Religious Affiliation
- Catholic
- Protestant
- Mormon
- Jewish
- Other
- None

Highest Level of Education
- Grade School
- High School (or GED)
- Some College
- Bachelor's Degree
- Graduate Student
- Master's Degree
- Doctorate Degree

Current Relationship Status
- Single, never married
- Divorced
- Widow
- Dating
- Married, First Marriage
- Married, 2nd or 3rd Marriage
- *How long have you been in your current relationship? _____________

How did you learn about me?
- Former Client
- Friend/Family Member
- Employer
- Hospital/Physician
- Another Professional
- Name: _____________________
- Other: ______________________

Please indicate problems that are a concern to (Circle all that apply)

you about yourself
chronic illness/pain:
depression
anxiety/Worries
stress
sexual abuse
eating disorder
relationship problem
physical problem
excessive alcohol/drugs
family relationships
sexual problems
parenting
self-esteem
suicidal thoughts
anger
grief
self-injury/self-mutilation
emotional abuse in childhood
physical abuse in childhood
other (please specify)
____

you about your partner
chronic illness/pain:
depression
anxiety/Worries
stress
sexual abuse
eating disorder
relationship problem
physical problem
excessive alcohol/drugs
family relationships
sexual problems
parenting
self-esteem
suicidal thoughts
anger
grief
self-injury/self-mutilation
emotional abuse in childhood
physical abuse in childhood
other: (please specify)
____

you about your relationship
(If applicable)
poor communication
arguments/fighting
not enough time together
physical violence
refuses/demands sex
partner differences
emotional abuse
partner too controlling
difficulty dealing with illness
other (please specify)
____

you about your children/family
(If applicable)
stealing, truancy, fighting
drugs/alcohol
sexual abuse
sexual abuser
divorce adjustment
death in family
self-injury/self-mutilation
peer relationships
difficulty dealing/with illness
other: (please specify)
____

Please indicate problems that are a concern to Circle all that apply)

occurred in your household before age 18
alcohol/drug addiction
physical abuse
emotional/verbal abuse
unwanted touching
financial problems
sexual abuse
divorce
lived in foster care
emotional distance
acute/chronic illness: __________

occurred to you before age 18
alcohol/drug addiction
physical abuse
emotional/verbal abuse
unwanted touching
financial problems
sexual abuse
divorce
lived in foster care
emotional distance
acute/chronic illness: __________

How often do you drink alcohol?
Never
Less than once a month
About once a week
2 to 3 days a week
4 to 6 days a week
Daily

How often do you use drugs?
Never
Less than once a week
About once a week
2 to 3 days a week
4 to 6 days a week
Daily

Do you drink now more than in the past?
Yes: _____ No: _____

Do you use drugs more often than the past?
Yes: _____ No: _____

Has anyone objected to your drinking?
Yes: _____ N: _____

Has anyone objected to your drug use?
Yes: _____ No: _____

When was the last time you drank alcohol or used drugs? _________________________________

How often do you use tobacco products?
Never
Daily
About once a week
2 to 3 days a week
4 to 6 days a week

Do you use tobacco products more than in the past?
Yes: _____ No: _____

Has anyone objected to your tobacco use?
Yes: _____ No: _____

I understand the information provided to be true and accurate.

Signature Date