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Adult Intake Form

Please fill out this form and bring it to your first session. Please note, the information provided here is protected as confidential information.

Date _____

Client's Name _____

Gender at birth □ Female □ Male Date of Birth_____ Age_____

Cell # _____ Work # _____

Which is the best number to reach you at _____May I leave a message at this number? _____

Email _____

Client's Address _____

City, State Zip _____

Client's Occupation _____

Employer _____

Primary Physician _____ Phone _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed Number of marriages _____

Name of Spouse (if applicable) _____

Spouse's Occupation _____

Who referred you to my practice? _____

Have you ever been in therapy before? □ Yes □ No

If so, name of previous therapist _____

Intake continued on the next page…

Children

Name	Age	Gender

Please list any history of mental health or substance abuse treatment (ex. alcohol or drugs, anxiety, depression, eating disorders, domestic violence, suicide attempts)

Treatment Issue	Date (s)	Treatment Modality (ex. Therapy or hospitalization)

List any current medications or supplements you are taking (if any)?

Dosage	Date Started	Reason

List any medical conditions you have been treated for (if any)?

Illness/Condition	Date of Diagnosis	Details

Intake continued on the next page…

General Health and Mental Health Information:

1. How would you rate your current **physical health**? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. How would you rate your current **sleep** habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. Please explain any specific sleep problems you are currently experiencing:

_____

_____

4. Are you currently experiencing overwhelming **sadness, grief, or depression**? □ No □ Yes If yes, for how long? _____ If yes, please describe:

_____

_____

_____

5. Rate the severity of these feelings on a scale of 1-5 (5 is most severe) _____
6. Any previous **suicide attempts**? □ No □ Yes If yes, how many attempts? _____
7. Are you currently experiencing **anxiety**, panic attacks, or have any phobias? □ No □ Yes If yes, how long? _____ If yes, please describe:

_____

_____

8. Rate the severity of these feelings on a scale of 1-5 (5 is most severe) _____
9. Do you **drink alcohol**? □ No □ Yes If yes, how frequently? □ Daily □ Weekly □ Monthly
10. Do you use **drugs**? ? □ No □ Yes If yes, which substance do you use? _____ If yes, how frequently? □ Daily □ Weekly □ Monthly
11. Have you ever been in an **abusive relationship** or experienced domestic violence □ No □ Yes If yes, when? _____
12. Do you have a history of an **eating disorders** □ No □ Yes If yes, which disorder? _____ 13. Have you or your family experienced any **significant life changes** or stressful events recently? (ex. loss, divorce, births, deaths, moves, hospitalizations, unemployment, and or financial problems)

_____

_____

_____

Intake continued on the next page…

14. What is the primary reason for seeking therapy at this time?

15. How long has the problem existed? _____

16. What attempts (if any) have been made to resolve these current issues?

17. What do you consider some of your strengths?

18. What qualities about yourself would you like to improve?

19. What would you like to accomplish in therapy?