

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.

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 _____

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

Intake continued on the next page...

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

Illness/Condition	Date of Diagnosis	Details

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 do you consider some of your weaknesses?

19. What would you like to accomplish in therapy?
