Adult Intake Form

Date _____

Full Legal Name: _____
Age: ____ Date of Birth: _____ Pronouns: _____
Social Security #:_____

Street Address:
_____

City: _____ State: _____ Zip: _____

Phone:_____ **Ok to leave a message: Y N**

Emergency contact: _____
Relationship to you _____
Address of emergency:_____
Phone:_____

Insurance Information
ID#_____ Name of Carrier _____
co-pay $_____
Deductible amount $_____
Limit on session per calendar year? Yes No

Health Information
Please answer the following questions using:
5- Excellent, 4- Good, 3 – Average, 2 – Poor, 1 – Failing

How would you rate your physical health:____
How would you rate your mental health:_____
How would you rate your spiritual health:_____ (if it does not apply, please use N/A)

Please list current symptoms (reasons you are here) and circle those that are most bothersome?
_____
_____

What are your therapy goals?
_____
_____

Medical Information

Do you now have, or have you in the past, had any of the following? Check those that apply:

Asthma___ Allergies___ Headaches___ Brain Injury___ Epilepsy___

Seizures___ Digestive Disorders___ Cancer___ Diabetes___

Breathing Problems___ Immune System Problems___ Heart Disease___

Arthritis___ Urinary Disorder___ Tuberculosis___ Thyroid Disorder___

Multiple Sclerosis___ Chronic Fatigue Syndrome___ Fibromyalgia___

Pregnancy___ (how many total) Miscarriage___ (how many total)

Abortion___ (how many total) Sexually Transmitted Disease___ HIV___ AIDS___

Sleep Disorder___ Other:_____

Are you under the care of a Doctor or other medical health professional: **Y N**

Name of PCP_____ Phone _____

Name of Specialist:_____ Phone _____

Please list any prescription medications, vitamins, over the counter medications, or herbal supplements you are taking you are currently :

_____

_____

Do you exercise: **Y N**
If yes, how often and what do you do:_____
Please indicate substances used (over the past 6 months)

Substance	**Current**	**Amount**	**Frequency**	**Age Of 1st use**	**Past use**	**Length of use**
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping pills						
Diet Pills						

Have you ever believed your substance was a problem for you:_____
Has anyone ever told you they believed your substance use was a problem:_____
Have you ever had a problem with work, relationships, health, the law, etc. due to your substance use?_____

Mental Health

Have you ever been in counseling/Therapy before:___
If yes, how was it helpful or effective:_____
_____

Are you currently receiving mental health services:___
If yes, please list name of practitioner and type of services you are receiving:
_____

Have you ever been diagnosed with a mental illness:_____
Please list name and when it began:_____

Have you ever been hospitalized for mental health concerns:_____
Please list dates and length of stay:_____

Has anyone in your family been diagnosed with mental illness:_____
Please list relationship and illness:_____

Have you ever attempted suicide:_____ List dates, method, and age at the time of attempts:_____
_____

Have you ever had suicidal thoughts? Please explain _____

Has anyone in your life, family or friends, attempted or committed suicide:_____
If yes, please name:_____
_____

Have you ever had any issues with food (restricting or purging)? Please describe
_____

Relationship Information

Are you currently in a relationship:_____ Are you married _____
How many years together:_____

Do you have any children:_____ Please list ages:_____
How many live with you:_____

Number of past serious relationships:___ Number of marriages:___
Number of divorces: ___

Is there any relationship you are coming to therapy to work on?_____
Please describe:_____
_____

Family Information

Were you adopted:___ If yes, at what age ___

Are your parents married or divorced:_____
If they divorced how old were you:____

Mother's current age___
Describe your relationship:_____

Father's current age___
Describe your relationship:_____

List siblings, ages and briefly describe the relationship:_____
_____
_____

Have you ever experienced a death of a family member or close friend:_____
If yes, who:_____

Please indicate if you or a member of your immediate family has experienced any of the following.

Event	Self	family	Relationship	Event	Self	family	Relationship
Emotional Abuse				Legal Problems			
Physical Abuse				Homelessness			
Sexual Abuse				Financial Problems			
Domestic Violence				Lived overseas			
Neglect				Military member			
Substance Abuse				Discrimination			
Serious Illness				Other:			
Accident or injury				Other:			

Spiritual or Religious Information

Do you engage in a personal faith practice:___
If yes, please describe:_____

Do you want to incorporate these beliefs into your therapy: **Y N**
Is there anything you would like me to know about your beliefs that would help you in therapy?

_____
_____

Education Information

Number of years of education completed:_____ Degree(s) achieved (mark all that apply) High school Diploma __ G.E.D.___
Vocational/Trade School ___
Associates Degree___ Bachelors Degree___ Masters Degree___
Doctorate Degree___ Other____

Vocational Information

Are you employed:___ Position and title:_____
If not working, how long have you been unemployed:_____
What type of work did you do:_____

Have you ever served in the military:____
Branch, rank, and current status:_____

Please list your personal hobbies and interests:_____
_____
_____

Legal Information

Have you ever been the victim of a crime: ____
If yes, please list date and event:
_____
_____

Are you currently involved in any legal situation: ____
If yes, please describe_____

Have you ever been convicted of a misdemeanor or felony: ___
If yes please briefly describe:
_____
_____
_____

Treatment Plan

Date:
Name:
Birth date:

Current Symptoms:

General procedures used in treatment: Cognitive-behavioral and experiential methods

Procedure's benefits, limitations, and risks: Benefits include improved functioning in social, vocational, educational, and/or relational areas.

Limitations are those of any therapy include: the skills of the therapist and the capabilities and potentials of the client. Risks include disturbance of emotional and functional aspects of your life.

Therapy Goals

_____

_____

_____

_____

I hereby acknowledge that I understand and accept this treatment plan with the understanding that it will be reviewed and revised as necessary, and at least annually.

Client Signature Date

Therapist Signature Date