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ADULT INTAKE FORM

Thank you for taking the time to complete this form. The information and history you provide to me will be helpful in planning services for you. Please answer each question carefully and ask about any question you don't understand. The information on this form is confidential and will not be released without your permission.

Today's Date: ________________________

How did you hear about me? Circle one:

Family member Friend Internet Insurance Child Advocacy Center
Other therapist Doctor Department of Human Services Attorney
Other: ____

Indentifying Information

Name: ________________________ Date of Birth: ____________ Age: _______ Sex: M or F
Race: _____________ Religion: ________________
Address: ____
City: ___________________ State: _____________ Zip Code: _______________
Home Phone Number: _______________________ Okay to leave a message? Y or N
Cell Phone Number: ________________________ Okay to leave a message? Y or N
Work Phone Number: _______________________ Okay to leave a message? Y or N
Occupation: ___________________ Place of Employment: ________________________
Relationship Status: _____________

Family Composition

Name	Age	Date of Birth	Relationship	How do they get along?

Medical History

Primary care provider: ____
Medications you are currently taking: ____
____
Have you previously attended therapy? Y or N
Who did you see? ____
Reason you were seen in therapy: ____
Type of therapy you received: ____
Was the therapy helpful? Circle one: Helpful Somewhat helpful Not helpful
Have you experienced any of the following? Please circle and describe.
-chronic illness: ____
-surgeries: ____
-hospitalizations: ____
-high fevers: ____
-head injuries: ____
-seizures: ____
-eating problems: ____
-sleeping problems: ____
-encopresis/enuresis: ____
-problems with coordination: ____
-other: ____

Current Stressors

Please circle any of the stressors you have experienced over the last 12 months:

Death of a parent	Divorce	Death of a spouse
Remarriage	Death of a family member	Death of a child
Personal injury or illness	Job loss	Sexual abuse (self)
Sexual abuse (family member)	Change in family member’s health	Birth of a child
Alcohol/drug addiction in family	Change in financial status	Vacation
Change in living condition	Change in residence	Change of job

Other: ____
____
____

Please describe why you are seeking therapy at this time: _______________________________
____
____
____

How long have you been experiencing these problems?_________________________________
____

What have you tried to help yourself so far? ____________________

____

____

Have you ever tried to hurt or kill yourself? Y or N

If yes, please describe: ____________________

____

____

If yes, when did this occur? ____________________

Please circle all behaviors that apply to you:

- Addictive Behaviors
- Agitation
- Aggressive Behavior
- Anger and Rage
- Anorexia
- Anxiety
- Attachment Problems
- Body Tension
- Bulimia
- Chronic Fatigue
- Compulsive Behavior
- Conflict with peers
- Constipation
- Depression
- Despair
- Difficulty Sleeping
- Dissociative Episodes
- Early Trauma
- Emotional Expression
- Emotionally Reactive
- Emotional Overwhelm
- Fear and Anger
- Fybroidmyalgia
- Headaches/Migraines
- Hyper-vigilance
- Impulsivity
- Irritability
- Irritable Bowel
- Lacking Boundaries
- Mental Calming
- Mood Swings
- Motivation
- Nightmares
- Night Terrors
- Obsessive Neg.Thoughts
- Obsessive Worry
- Panic Attacks
- Paranoia
- Perfectionism
- Phobias
- Physical Tension
- Poor Concentration
- Seizures
- Self-Esteem
- Self-Injurious Behavior
- Sexual Concerns
- Short-Term Memory
- Sleep Walking
- Stomachaches
- Suicidal Thoughts
- Trauma
- Verbal Expression
- Vertigo
- Withdrawn
- Working Memory

Other: ____________________

Which of the above behaviors are the most concerning to you? ____________________

____

Is there any other information that would be important for me to know about you?

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Signature of Client: ____________________ Date: ____________________

Signature of Therapist: ____________________ Date: ____________________