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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   Brochure   Attorney   Department of Human Services

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 well do they get along with other family members?

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: ____

-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 members 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
Bulima	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 Boundries	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: ______________