Laura Molzer, MS, LMFT

Laura Molzer Therapy, LLC
1200 S. College Avenue, Suite 208
Fort Collins, CO 80524

Phone: (970) 672-5535
Fax: (970) 672-5536

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 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?

_____

_____

_____

_____

_____

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____