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Adult Intake Form

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address _____

Primary phone _____

Referral Source: _____

Please indicate your primary symptom concerns:

□ anxiety or worry	□ depression or mood changes	□ anger / irritability
□ family conflict	□ relationship problems	□ employment / job concerns
□ grief or loss `	□ panic attacks	□ obsessive compulsive behavior
□ self-injury	□ suicidal thoughts	□ suicide attempts
□ eating problems	□ sleep difficulties	□ school problems
□ social concerns	□ substance abuse	□ trauma or assault

Other _____

What would you like to accomplish in therapy experience?

_____

_____

Family History

Family Structure (Please list marriages, divorces, deaths, traumatic events, losses)

_____

_____

_____

Children / Stepchildren (names, ages, relationship to you, place of residence)

_____

_____

_____

_____

_____

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Social History

Relationship status □ Single □ Married □ Partnered □ Divorced/Separated □ Widowed

Employment status □ Homemaker □ Employed □ Unemployed □ Retired
Current Position: _____ Employer: _____

Student status □ FT Student □ PT Student
Academic institution _____ Dates _____
Highest Level of Education: □ High School □ Junior College □ Bachelor's degree
□ Master's Degree □ Doctoral degree

Religious Affiliation: _____ Does religion play an important role in your life? _____
Military History:

_____
Financial Stressors:

_____
Legal Problems:

_____
Interests/Hobbies:

_____

Please describe your use of the following, if any:
Alcohol: _____Tobacco: _____
Marijuana: _____ Other drugs: _____
Herbal supplements:

_____

Medical History

Describe current physical health and any medical concerns:

_____
_____

Current Medications:

_____
_____

Describe sleep habits:

_____
Describe eating habits:

_____
Describe exercise routines:

_____

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Allergies:

_____

History of accidents requiring medical care _____

Previous mental/behavior health services (therapy, psychiatry, etc.) □ Yes □ No

Provider: _____ Dates of service: _____

Provider: _____ Dates of service: _____

Previous Hospitalizations (include psychiatric): □ Yes (please list) □ No

Location/purpose: _____ Dates of service: _____

Location/purpose: _____ Dates of service: _____

History of trauma or abuse □ Yes (please describe) □ No

_____

Please list any blood relatives with learning problems or psychiatric problems, including depression, anxiety, suicide attempts, hospitalizations, alcohol/drugs, etc: _____

_____

Additional comments or concerns:

_____

_____

_____