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ADULT INTAKE FORM

Please note the information provided here is kept confidential.

Name _____

Birthdate: _____/_____/_____ Gender

Please list family and/or household members, and ages _____

_____

Home Address_____
(Street and Number)

_____
(City) (State) (Zip)

Cell/Other Phone: _____ May we leave a message? Yes No

Cell/Other Phone: _____ May we leave a message? Yes No

Emergency Contact: Name, relationship, and phone

_____

E-mail: _____ May we email you ? Yes No
*Please note that email communication is not considered confidential medium of communication.

Reason for your visit today, and what you hope to accomplish out of your time in therapy:
_____

_____

Referred by (if any) _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc?
No Yes Previous therapist or practitioner _____

Are you currently taking any prescription medication?
If yes, please list, _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Satisfactory Good Very Good

Please list any specific health problems currently experiencing or being treated:
_____

2. How would you rate your sleep habits? (please circle)
Poor Satisfactory Good Very Good

3. How many times does you exercise per week? _____

4. What are your favorite activities, hobbies? _____

5. Please list any concerns about your eating patterns or appetite:

_____

6. Are currently experiencing overwhelming sadness, grief or depression?
No Yes If yes, for how long?_____

7. Are you currently experiencing anxiety, panic attacks or any phobias?
No Yes If yes, when did this begin ?
_____

8. Have you experienced any major change recently? _____

_____

_____

9. Are you currently employed? yes no
if yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful? _____

10. What is your alcohol intake per week? _____

11. Do you engage in recreational drug use? Yes No

12. Have you ever had suicidal or homicidal thoughts? Yes No

If yes, how recently? _____

13. Are you currently experiencing any chronic pain? Yes No _____

If yes, are you receiving treatment for it? _____

14. Are you currently involved in a relationship? yes no
On a scale of 1-10, how would you rate it? _____

15. Have you ever been exposed to trauma or violence? yes no Please explain:

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, please identify any family history of mental health issues, and include the family member's relationship to you.

	Please circle	List Family Member
Alcohol/Substance Abuse	yes no	
Anxiety	yes no	
Depression	yes no	
Domestic Violence or Abuse	yes no	
Eating Disorders	yes no	
Obsessive Compulsive Disorders	yes no	
Phobias	yes no	
Schizophrenia	yes no	
Bipolar Disorder	yes no	
Suicide Attempts	yes no	

Please list any other history here:

Please feel free to share any additional information below that you feel will be useful for the therapist to know about you and/or family.