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**Adult Intake Form**

Please fill this form out as completely as possible. Feel free to write "same as..." where appropriate. The information will be confidential. If you are uncomfortable answering any of the questions or some do not apply, feel free to skip them (use the back if you need additional space). Thank you.

*Identifying Information*

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Phone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_ Email: \_\_\_\_\_

Home Address Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Additional Emergency Contact \_\_\_\_\_ phone \_\_\_\_\_

Current Occupation/ Employer \_\_\_\_\_

And/or

Current College or Technical School \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Last visit \_\_\_\_\_

Who else lives in your household?

Name	Age	Relationship

Immediate/important family members who live elsewhere?

Name	Age	Relationship


*Client Health*

Please describe your general health and list any medical problems \_\_\_\_\_

\_\_\_\_\_

Allergies (including medication allergies) \_\_\_\_\_

\_\_\_\_\_

How many hours per week do you exercise? \_\_\_\_\_ Type of exercise \_\_\_\_\_

\_\_\_\_\_

How many hours a night do you sleep? \_\_\_\_\_ How long does it take you to get to sleep? \_\_\_\_\_

Do you sleep through the night? \_\_\_\_\_ *If not please explain* \_\_\_\_\_

\_\_\_\_\_

Are you troubled by any fears/worries/anxieties? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

Have you ever engaged in self-harm (cutting, for instance)? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

Have you ever thought of or attempted suicide? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

Has anyone ever expressed concern about your health? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

Has anyone ever expressed concern about your eating habits or weight? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

Has anyone ever expressed concern about your drinking or drug use? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

**Medications (Psychotropic or other):**

Medication	Dosage/ Frequency	Prescriber	Prescriber Phone Number

*Client/Family History (use the back if you need additional space)*

Is there any history of mental illness or emotional problems in your family? \_\_\_\_\_ *If so please explain*

\_\_\_\_\_

Is there any history of alcohol or drug abuse in your family? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

Have you ever been physically or sexually abused? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

Have you experienced the death of a close family member or a friend? \_\_\_\_\_ *If so please explain*

\_\_\_\_\_

Have you ever had counseling before? \_\_\_\_\_ *If so please explain* \_\_\_\_\_

\_\_\_\_\_

*Present Concerns*

What events, experiences, or changes have led you to choose counseling? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What specific issues do you want to work on in counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your present life, how do you deal with problems or conflicts?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please mention any other special concerns, history or information that might be helpful for me to know about you:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date