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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 _____________

Main Phone Number: _______________ Other Phone Number: _________________ 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