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ADULT INTAKE FORM

Name:			
	Age:	**DOB:**	
Address:			
Telephone numbers:	**Home:**	**Work:**	**Cell:**
Can I leave a message at the above number?	**YES/NO**	**YES/NO**	**YES/NO**
Preferred way to be contacted (circle one):	**Home**	**Work**	**Cell**
May I contact you by E-mail? YES/NO		**Email:**	

Please include spouse/partner information if seeking couples/family therapy:

Name:			
	Age:	**DOB:**	
Address:			
Telephone numbers:	**Home:**	**Work:**	**Cell:**
Can I leave a message at the above number?	**YES/NO**	**YES/NO**	**YES/NO**
Preferred way to be contacted (circle one):	**Home**	**Work**	**Cell**
May I contact you by E-mail? YES/NO		**Email:**	

In case of an emergency, who may I contact on your behalf?

Name:	**Relationship:**
Phone Number:	**Address:**

Children: (List all children, including biological, adopted, foster, and step children)

Name	Age	Relationship	City, State	Lives at home?
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO

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Relationship Status: (Circle all that apply)

Single	Married	Divorced	Separated
Widowed	Remarried	Long-term Relationship	Cohabitating

Current partner's name:	**Partner's Occupation:**	**Length of Relationship:**
How satisfied are you with your current relationship (on a scale from 1-10)? (very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)		
What is your occupation?	**Employer:**	
Do you enjoy your occupation: YES/NO	**Average hours worked per/week:**	

Have you ever received or given abuse: YES/NO	**If yes please circle type:** Physical Emotional Sexual Neglect Other

Do you have a primary care physician? YES/NO	**Physicians name:**
Are you under the care of a psychiatrist? YES/NO	**Psychiatrists name:**

Are you under the care of a specialist? YES/NO					
If yes, please circle type of specialist:					
Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility	Nephrologist
Neurologist	Nutritionist	Occupational Therapist	Oncologist/ Hematoloist	Orthoedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Please list any chronic illness, disabilities, or medical conditions that you have been diagnosed with:

Illness/Disability	Dates

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List all medications you are currently taking:

Medication	**Dosage**	**Treating**
Are you taking the medications according to your doctor's recommendation? YES/NO If No, briefly explain:		

Do you drink alcoholic beverages? YES/NO	**If yes how many alcoholic beverages do you drink** ____ weekly ____ daily
Do you think you have a drinking problem" YES/NO	**Does anyone else think you have a drinking problem?** YES/NO
Do you smoke? YES/NO	**If yes, how many cigarettes/packs do you smoke?** ____cig./day ____ packs/day
If yes, when did you start smoking?	**Have you ever tried to quit?** YES/NO
Have you in the past or currently: used, abused, or experimented with illegal drugs? YES/NO	**If yes, briefly explain:**

Have you ever attempted/seriously contemplated suicide? YES/NO
If yes, describe briefly and indicate dates:
Have you ever had a psychiatric hospitalization? YES/NO
If yes, describe briefly and indicate dates:

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Therapy Experiences and Expectations:

Are you currently seeing another therapist? YES/NO			
If yes, please indicate the therapist's name:			
Have you ever been in therapy in the past? YES/NO			
If yes, please fill out the following on your previous counseling experience(s):			
Therapist	**Location**	**Dates**	**Reason for therapy**

Briefly describe your reason(s) for seeking therapy at this time:

What goals do you wish to accomplish during the therapy process?

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Is there anything else you would think would be important for me to know about you and your family?