

ADULT CLIENT INTAKE FORM

DATE: _____



Please take your time in providing the following information. The questions are designed to help us begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by: _____ Agency: _____

Contact Information: _____ Email: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

GENERAL INFORMATION

Last Name: _____ First Name: _____

Age: _____ DOB: ____/____/____

Street Address: _____

City _____ State: _____ Zip: _____

Ethnicity: White Black Hispanic Asian Other

Gender:

- Male
- Female
- Transgender
- Declined
- Other: _____

Sexual Orientation:

- Straight
- Lesbian
- Gay
- Bisexual
- Declined
- Other: _____

Preferred Pronoun: _____

Email Address: _____

Phone (H): _____ May we contact you here? Yes No

Phone (C): _____ May we contact you here? Yes No

Phone (W): _____ May we contact you here? Yes No

May we leave a message for you? Yes No May we text you? Yes No

Occupation: _____ Employer: _____

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School: _____ Grade Level: _____

Education Level: High School Some College Bachelor's Degree Graduate School

Hours worked per week: _____ Estimated annual income: _____

How did you hear about us? Internet Physician Friend Parent Other

Name of person who referred you: _____

May we thank them for referring you? Yes No

RELATIONAL STATUS

Current relational status:

Single

Dating

Domestic Partner (how long?) _____

Engaged (how long?) _____

Married (how long?) _____

Separated (how long?) _____

Divorced (how long?) _____

Widowed (how long?) _____

If in a current relationship, how long have you been with your partner and what is your partners name:

On a scale of 1-10 (best), how would you rate your current relationship? _____

Are you content with your current relational status: Yes No

(if no, briefly explain): _____

Children: List your children (living or deceased), children you have placed for adoption, along with step-children. (Use back if necessary.)

Name	Sex	Age or Year of Death	Relationship (i.e. Natural, Step, Adopted)	Living with you?	Name of other parent

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Have you ever had a miscarriage or medical abortion? Yes No If yes, when? _____

RELIGIOUS BACKGROUND

Briefly describe the religious environment of your home as you were growing up: _____

Do you regularly attend a place of worship? Yes No If yes, where? _____

EDUCATION

Fill in all that apply: Years of education: _____ Currently enrolled: Yes No

_____ High School grad/GED _____ College _____ Vocational: _____ Graduate

School Other training: _____

Special circumstances: _____

MILITARY

Military experience? Yes No Combat experience? Yes No

Where: _____ Branch: _____

Type of discharge: _____

Length of service: _____

Rank at discharge: _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past: _____

SUBSTANCE USE

Please check substances you use on a weekly/monthly (circle) basis:

Alcohol: _____ x per week / month Marijuana: _____ x per week / month

Cocaine: _____ x per week / month Heroine: _____ x per week / month

Meth: _____ x per week / month Ecstasy: _____ x per week / month

Check all that apply:

_____ I believe that my substance use may be a problem.

_____ I believe that my partner's substance use may be a problem.

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MEDICAL INFORMATION:

Primary Physician: _____ Phone: _____ Fax: _____

City/State: _____ Date of your last physical exam? _____

Describe your current health: [] Great [] Good [] Fair [] Poor

Specialty (e.g. Family Practice, OB/GYN, Oncology/Hematology): _____

Are you currently receiving medical treatment? [] Yes [] No

If yes, please specify: _____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had. (Use back if necessary.)

Height: _____ Weight: _____

Has your weight changed in the last 2-3 months? Yes No (If so, how): _____

List all current medications you are taking, including those you seldom use or take only as needed. Also include any over-the-counter herbal medications and/or supplements. (Use back if necessary.)

Medication/Supplement	Dosage	Purpose for Usage

Are you compliant with your medications and follow up appointments? [] Yes [] No

Any barriers in being able to meet your own medical needs? [] Yes [] No

If yes, please describe barriers: _____

PRESENTING ISSUES AND GOALS:

Please describe reason for seeking services (What are the issues or problems of concern?)

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LEVEL OF DISTRESS:

Indicate how distressed you are by placing a check or "X" on the scale below
(1= Very Little Distress; 10=Extreme Distress):

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	8	9	10

Are you currently experiencing any suicidal thoughts? [] Yes [] No

Have you experienced them in the past? [] Yes [] No

Have you ever attempted suicide? [] Yes [] No If yes, when & how? _____

Have any of your friends or family ever committed or attempted suicide? [] Yes [] No

If yes, please explain briefly: _____

CURRENT STATUS:

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Headaches	[] Past	[] Present
Visual Trouble	[] Past	[] Present
Weakness	[] Past	[] Present
Difficulty Breathing	[] Past	[] Present
Change in Appetite	[] Past	[] Present
Hearing Voices	[] Past	[] Present
Dizziness	[] Past	[] Present
Sleep Trouble	[] Past	[] Present
Tension	[] Past	[] Present
Intestinal Trouble	[] Past	[] Present
Tiredness	[] Past	[] Present
Seeing Things	[] Past	[] Present
Stomach Trouble	[] Past	[] Present
Trouble Relaxing	[] Past	[] Present
Rapid Heart Rate	[] Past	[] Present
Hearing Noises	[] Past	[] Present
Pain	[] Past	[] Present
Other: _____	[] Past	[] Present

Please check any of the following problem areas that pertain to you and/or your family:

Stress	[]	Temper	[]	Confidence	[]
Panic	[]	Bad Dreams	[]	Recent Loss	[]
Guilt	[]	Unwanted Thoughts	[]	Nervousness	[]
Recent Death	[]	Impulsive Behavior	[]	Unhappiness	[]
Inferiority Feelings	[]	Sexual Problems	[]	Apathy	[]
Shyness	[]	Legal Matters	[]	Grief	[]
School Problems	[]	Drug Use	[]	Defective Feelings	[]
Emotional Abuse	[]	Career Choices	[]	Fears	[]

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Communication	[]	Being a Parent	[]	Aggressiveness	[]
Verbal Abuse	[]	Disaster	[]	Racing Thoughts	[]
Anger	[]	Anxiety	[]	Loss of Control	[]
Concentration	[]	Depression	[]	Compulsivity	[]
Memory	[]	Terminal Illness	[]	Abortion	[]
Self-Control	[]	Hopelessness	[]	Eating Problems	[]
Pregnancy	[]	Loneliness	[]	Trouble with Job	[]
Trauma	[]	Friends	[]	Making Decisions	[]
Alcohol Use	[]	Physical Abuse	[]	Finances	[]
Ambition	[]	Sexual Abuse	[]	Other : _____	[]

PREVIOUS COUNSELING:

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received. (Use back if necessary.)

THERAPIST	LOCATION	DATES	REASON

FUNDING SOURCE

[] SELF PAY [] INSURANCE MEDICAID [] INSURANCE COMMERCIAL [] OTHER

POLICY NAME: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ INSURANCE PHONE #: _____

CLAIM ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

PRINT NAME: _____ DATE: _____

SIGNATURE (LEGAL GUARDIAN IF UNDER 18): _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the release of any medical/psychiatric information acquired in the course of my examination/treatment to my health and hospital insurance companies to facilitate payment for services rendered.

PRINT NAME: _____ DATE: _____

SIGNATURE (LEGAL GUARDIAN IF UNDER 18): _____