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Adult Intake Form

Please complete this form in legible handwriting and bring it to your first session.
The information you provide is protected as confidential information.

Name: _____ Preferred Name: _____
(First) (Middle Initial) (Last)
Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No
Cell/Other Phone: _____ May I leave a message and/or text? □Yes □No

Birth Date: _____ /_____ /_____ Age: ____
Gender Identity: □ Male □ Female □ Other:_____ □ Decline to State
Sexual Orientation: □ Heterosexual □ Gay □ Bisexual □ Other: _____ □ Decline to State
Racial/Ethnic Identity: _____ □ Decline to State
Language Preference: _____
Religious/Spiritual Beliefs: _____ □ Not Applicable
Education: □ some highschool □ high school diploma □ some college □ college graduate
□ postgraduate

Marital Status:
□ Married □ Divorced □ Never Married □ Separated □ Domestic Partnership □ Widowed

Please list any children and ages: _____

Briefly, what is the main concern for which you are seeking my assistance? (i.e., depression, anxiety, relationship, stress, parenting, etc.)
_____
_____

Have you previously been in counseling before?
□ No □ Yes
If so, with whom? Was it helpful? Why or why not?
_____
_____

HEALTH AND SOCIAL INFORMATION:

1. How is your physical health at present?
□ Very Good □ Good □ Satisfactory □ Unsatisfactory □ Poor
Please list any specific health problems you are currently experiencing:

_____
Please list any known allergies: _____
Name of Primary Care Physician: _____ Phone Number: _____
Would you like for me to be in contact with him/her regarding our sessions?
□ Not necessary at this time □ Yes

2. Are you currently taking any prescription ***non-psychiatric*** medication?
□ No □ Yes, please list:_____
Name of Prescribing Dr: _____ Phone Number: _____

3. Are you currently taking any prescription ***psychiatric*** medication?
□ No □ Yes, please list with dates prescribed: _____
Please list all previously prescribed *psychiatric* medication with dates: _____
_____
Name of Prescribing Dr: _____ Phone Number: _____
Would you like for me to be in contact with him/her regarding our sessions?
□ Not necessary at this time □ Yes
Have you been assigned a formal mental health diagnosis? Please list: _____
_____

4. How would you rate your current sleeping habits?
□ Very Good □ Good □ Satisfactory □ Unsatisfactory □ Poor
Please list any specific sleep problems you are currently experiencing:
_____

5. How many times per week do you generally exercise? _____
What types of exercise to you participate in: _____

6. Please list any difficulties you experience with your appetite or eating patterns:
_____

7. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes, for approximately how long? _____

Check **ALL** applicable symptoms:

□ sadness more days than not	□ weight loss or weight gain	□ poor concentration
□ lethargy/feeling tired	□ increased or decreased appetite	□ crying
□ unmotivated	□ insomnia or hypersomnia	□ guilty or hopeless
□ loss of interest in activities	□ irritability/mood swings	□ suicidality

8. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes, when did you begin experiencing this? _____

Check **ALL** applicable symptoms:

□ ruminating thoughts	□ irritability/restlessness	□ difficulty sleeping
□ difficulty concentrating	□ difficulty making decisions	□ excessive worry
□ sweating, trembling	□ upset stomach/diarrhea	□ headaches

9. Are you currently experiencing any chronic pain?
□ No □ Yes, please describe? _____

10. Are you currently thinking about hurting yourself? □ No □ Yes, by what means? ____
11. Have you ever thought about hurting yourself? □ No □ Yes, dates: _____
12. Have you ever tried to commit suicide? □ No □ Yes, dates: _____
13. Have you ever self-harmed via cutting, etc.? □ No □ Yes, dates: _____
14. Have you ever been hospitalized for psychiatric reasons? □ No □ Yes, dates: _____

15. Do you drink alcohol? □ No □ Yes, how many drinks per week?_____
16. Do you engage in recreational drug use? □Daily □Weekly □Monthly □Infrequently □Never
    Types: □ marijuana □ nicotine □ heroin/cocaine □ inhalants
    □ hallucinogens (LSD, mushrooms) □ tranquilizers/sedatives (Xanax, sleeping pills)
    □ stimulants (ecstasy, methamphetamine, cocaine)
17. Have you ever participated in a substance abuse program? □ No □ Yes, dates:_____
18. Would you like to address any substance use concerns in therapy? □ No □ Yes

19. Are you currently in a romantic relationship? □ No □ Yes, for how long? _____
On a scale of 1-10 (10 being the best), how would you rate your relationship overall? _____
On a scale of 1-10 (10 being the best), how would you rate your physical intimacy? _____
On a scale of 1-10 (10 being the best), how would you rate your emotional intimacy? _____

20. Please list the names and relationships of those you consider to be a support to you:
_____

21. What significant life changes or stressful events have you experienced recently?
_____

FAMILY HISTORY:

Please answer the following regarding your family of origin (ie. your parents and siblings)
My parents are □ married □ divorced □ deceased, who & when? _____
My siblings names and ages are: _____
My family is □ intact □ estranged □ intact and estranged depending on the family members

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandfather, aunt, etc.).

Diagnosis		**List Family Member(s)**
Alcohol/Substance Abuse	□ No □ Yes	_____
Anxiety	□ No □ Yes	_____
Depression	□ No □ Yes	_____
Domestic Violence	□ No □ Yes	_____
Eating Disorders	□ No □ Yes	_____
Obesity	□ No □ Yes	_____
Obsessive Compulsive Behavior	□ No □ Yes	_____
Schizophrenia	□ No □ Yes	_____
Suicide Attempts	□ No □ Yes	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation?

_____

2. Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

3. Are you currently experiencing any legal issues? (ie. divorce, DUI, etc.) Please explain:

_____

4. What do you consider to be some of your strengths?

_____

5. What are some effective coping strategies that have worked for you?

_____

_____

6. What are some negative coping strategies you engage in?

_____

_____

7. What are some of your goals for therapy?

_____

_____

Thank you for taking the time to fill out this questionnaire. ~Rebecca Toner, LMFT