ADULT INTAKE FORM

Please fill out this form as completely as possible. The information will help me in our work together and it will make our first session together much more productive. If you do not desire to answer any question, write, "Prefer not to answer."

CLIENT NAME: ____ DATE: ___________

GENDER: Male ___ Female ___ Transgendered ___ Transsexual ___ Intersex ___ Other ___

DATE OF BIRTH and PLACE OF BIRTH: __________________________________ AGE: ____

ADDRESS: ____

TELEPHONE: H: ________________ Cell: ________________ Work/Off: ________________

E-MAIL: ____

NUMBER WHERE I CAN LEAVE CONFIDENTIAL VOICEMAIL: __________________________

HIGHEST GRADE/DEGREE: ________________ TYPE OF DEGREE: ____________________

EMERGENCY CONTACT: __________________________ TELEPHONE: _________________

WHO REFERRED YOU?
___ Google
___ Psychology Today
___ Theravive
___ Other web search
___ Referred by an individual: Please provide their name: ________________________________
___ Other: Please list: ____

OCCUPATION (former, if retired):
____

WHY ARE YOU SEEKING HELP? (Be as specific as you can: when did the concern start, how does it affect you?):
____
____
____
____
____
____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___ Very severe ____

What gives you the most joy or pleasure in your life?
____
____

What are your main worries and fears?
____
____

What are your most important hopes or dreams?
____
____

Have you ever had an experience that you consider traumatic? When did this happen and does the experience still bother you now? What was the traumatic event?
____
____

Have you ever had a period of time when you felt like you needed less sleep or found that you were sleeping less, but didn't feel tired?
____
____

Have you ever had a period of time when you felt like you had more energy than usual or you were more productive, happy or irritable than usual? If so, please explain:
____
____

FAMILY/SOCIAL

CURRENT: Marital/relationship status: ________________ Partner Name: _________________

Years together: ___ Do you live together? ___

PRESENT SPOUSE/PARTNER. Please describe their occupation, education and what your relationship is like:
____
____

Please list everyone who lives in your house with you, including pets (what is their relationship to you?):
____
____
____
____

PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):
____
____
____

Describe your relationships with your family members. Be specific about different relationships you have with different individuals:
____
____
____
____

COMMUNITY & SPIRITUALITY:
____
____
____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

____
____
____

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____
____
____

MEDICAL AND TREATMENT HISTORY

HEALTHCARE PROVIDERS. Please list name and phone number of medical doctors, therapists or other providers whose care you are currently under:

____
____
____
____

PHYSICAL. When was your last physical exam? Please give date, physician/facility and describe any findings:

____
____
____

Have you ever been diagnosed with hyper/hypothyroidism, high blood pressure, vitamin D deficiency or low testosterone? If yes, please describe diagnosis and date:

____
____

Do you currently have any medical conditions/injuries/disabilities? Please list and describe how they affect you?

____
____
____

LIST ANY MEDICATION (prescriptions, supplements or over the counter medications) you are currently taking, the dosage and why you are taking it:

____
____
____

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated number of sessions, name, degree, initial reason for therapy, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1.

____
____
____
____

2.
____
____
____
____

3. *USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

Have you ever attempted suicide? If so, please describe the circumstances, including ages, reasons, how, etc.:
____
____
____

Have you ever been treated for drug/alcohol abuse or addiction (AA, NA, treatments)? If so, please list:
____
____

LIFESTYLE

EXERCISE. Please describe your activity level, forms of exercise and number of times per week:
____
____

DIET: Describe your diet and whether you consider it to be healthy for you:
____
____

ALCOHOL: Number of drinks per day: _____ Per week: _____

Caffeine: Types of caffeinated drinks: ___________________________ Number per day: _____

Marijuana: Amount, frequency, method of use: ____

Other recreational substances: ____

SEX LIFE. Are you currently satisfied with your sex life? _____________________________

Method of contraception/prevention of STDs: ____

Sexual Identity: Heterosexual ___ Homosexual ___ Bisexual ___ Other ____

ESTIMATE HOW MANY HOURS/DAY YOUR SON/DAUGHTER SPENDS ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook/Instagram: ___ YouTube: ___ Gaming: ___ Texting: ___ Browsing: ___

Work/School: ___ Other: ___

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:
____
____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):
____
____
____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.