

Adult Intake Form for ages 18 and up

Welcome! Please complete this form so we can better understand your circumstances.

Client's Full Legal Name: _____ Date of Birth: _____

Who is completing this form? ___ Self /Other: _____
(Name & Relationship to Client)

Contact Information:

Client's Residence: _____

· OK to send mail to the above address? Yes No (please circle one)

Client's Phone Number: (_____) _____ (please circle one): Cell Home Work

· OK to leave voice messages? Yes No (please circle one) OK to text? Yes No (please circle one)

Client's Secondary Phone Number: (_____) _____ (please circle one): Cell Home Work

· OK to leave voice messages? Yes No (please circle one) OK to text? Yes No (please circle one)

Client's Email Address: _____

· OK to communicate through email? Yes No (please circle one)

Emergency Contact Information:

(Living with you?)

Name: _____ Relationship: _____ Yes No

Address: _____

Phone Number: _____ Alternate phone number: _____

Insurance Information:

Primary Insurance ID or Contract# _____ **Group #** _____

Name of Insurance: _____

Subscriber (who holds the policy): _____ Subscriber's DOB: _____

PO Box for claims (on the back of the card): _____

Secondary Insurance ID or Contract# _____ **Group #** _____

Name of Secondary Insurance: _____

Subscriber (who holds the policy): _____ Subscriber's DOB: _____

On the back of the card, is there a PO Box for claims? _____

What is the primary concern that you would like addressed in counseling? _____

Have you had any mental/behavioral health treatment in the past? If so, when and where? Please explain:

Personal Information:

Please indicate which of the following you have experienced in the last two years with an X or check:

- | | | |
|---|---|---|
| <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Feeling hopeless or worthless | <input type="checkbox"/> Anxiety or panic attacks |
| <input type="checkbox"/> Gambling in excess | <input type="checkbox"/> Suicidal or self-harm thoughts | <input type="checkbox"/> Avoiding going anywhere |
| <input type="checkbox"/> Loss of job | <input type="checkbox"/> Suicide attempt(s) | <input type="checkbox"/> Death of a close friend |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Significant weight gain/loss | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Angry or easily irritable | <input type="checkbox"/> Death in the family |
| <input type="checkbox"/> Motor accident/injury | <input type="checkbox"/> Problems with self-control | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Divorce | <input type="checkbox"/> New medical diagnosis |
| <input type="checkbox"/> Moved (relocated home) | <input type="checkbox"/> Started/restarted college | <input type="checkbox"/> Eating concerns |
| <input type="checkbox"/> Gender identity issues | <input type="checkbox"/> Problems with family relationships | |

Race and Ethnicity (optional):

- | | | |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian American or Asian | <input type="checkbox"/> African American |
| <input type="checkbox"/> European American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Two or More Races | <input type="checkbox"/> Other: _____ | |

Education Status:

- | | | |
|---|---|--|
| <input type="checkbox"/> Non High School Graduate | <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Some College |
| <input type="checkbox"/> Associate's degree | <input type="checkbox"/> Bachelor's degree | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> Doctorate degree | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Current Student, If yes: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time | Graduation date/year: _____ | |

What was the degree earned, and when? _____

Employment Status:

- | | | |
|--|---|--|
| <input type="checkbox"/> Full Time (30+ hours) | <input type="checkbox"/> Part Time (less than 30 hours) | <input type="checkbox"/> Volunteer or Internship |
| <input type="checkbox"/> Stay at home parent | <input type="checkbox"/> Retired | <input type="checkbox"/> Unemployed |

Military history? Yes No (circle one) If yes, please indicate when, how long, and what branch:

Sexual Orientation/Status (optional): _____

Which gender do you identify with? Female Male Other Unsure

If other, please specify: _____

Spirituality (optional):

Religious affiliation? Yes No (circle one) If yes: _____

Legal History (if applicable):

Any involvement with the legal system? Yes No (circle one) If yes, arrests or pending charges? Yes No (circle one)

Current probation or parole? Yes No (circle one) Name of Officer: _____

Friend of the Court or CPS involvement? Yes No (circle one)

If yes to any of the above questions (*Legal History*), please explain:

Substance Abuse History (if applicable):

Do you drink alcohol? Daily use Occasional Use None

Do you use tobacco? Daily use Occasional Use None

Do you use drugs? Daily use Occasional Use None

Has alcohol/drug use interfered with family, work, health, or interpersonal life? Yes No

If yes, please explain: _____

Have others viewed your use as a problem? Yes No

Have you ever tried to cut down on your alcohol or drug use or quit using? Yes No

If yes, please explain: _____

Have you had any prior substance abuse treatment? Yes No

Family and Personal or Supportive Relationships:

Living with you?

Name: _____ Age: _____ Relationship: _____ (circle one)
Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Trauma History (if applicable): (please circle one) If yes, when? Please include any information you feel is important.

Emotional Yes No _____

Neglect Yes No _____

Physical Yes No _____

Sexual Yes No _____

Verbal Yes No _____

Medical History:

Have you had any medical procedures? Yes No (circle one) If yes, please explain: _____

Medical Conditions and Diagnosis:

_____	When DX: _____	Treatment: _____
_____	When DX: _____	Treatment: _____
_____	When DX: _____	Treatment: _____

Please list current medications and what they are taken for:

Name of medication, dose (mg, ml, sublingual, etc.), and frequency	What is it intended for?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please attach another page if necessary.

Obstetrical History (if applicable):

Please list number of the following:

Pregnancies _____ Full-Term _____ Pre-Term _____ Abortions _____ Miscarriages _____
Tubal Pregnancies _____ Multiples _____ Living Children _____

Any additional information for your treating provider? _____

Thank you for taking time to complete this form.

Client, Parent or Legal Guardian Signature: _____ Date: _____

Signature of Treating Provider: _____