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Adult Therapy Intake Form

Last Name: _____First Name: _____ MI: _____

□___Parent/Guardian of patient? Name/Relationship to Patient: _____
Today's Date: _____/_____/_____ □ Male □ Female S.S.#_____
Date of Birth: _____/_____/_____ Age: _____
Physical Address: _____ Apt. _____ City: _____
State: _____ Zip: _____
Billing Address: _____ Apt. _____ City: _____
State: _____ Zip: _____
Home Phone _____ Work: _____ Cell/Alternate.: _____
Fax: ( ) _____-_____ E-mail: _____
Employer: _____ Occupation: _____
Employer Address: _____ Telephone: ( ) _____-_____

EMERGENCY CONTACT
Name: _____ Relationship to you _____
Address: _____
City: _____ State: _____ Zip: _____
Daytime Phone: _____ Evening: _____ Cell/Alt: _____

REFERRED BY:
_____
Where were you born? _____
What is your ethnic identity? _____
Religious preference:_____
Do you work at the present time?
_____No
_____Yes, Full or part time? _____
_____Student, Full or part time?
_____Homemaker
_____Retired
_____Supported by savings, family, etc...

If you are employed, where do you work?_____
What is the nature of your work?

_____
_____

How long have you been at your present job? _____
What were your previous jobs?

_____
_____

What is the highest grade of school you completed? Any problems in school?

_____
_____

If you are a student, where do you attend school?

_____

List any major physical illness, hospitalizations, accidents that you have had and at about what age they occurred:

_____
_____
_____

Have you had past psychiatric hospitalizations? _____Yes _____No
If yes, please state where and reason for hospitalization

_____
_____
_____

What prescribed medications do you take regularly, if any?

_____
_____
_____

What recreational substances do you use / have you used in past, if any (please include alcohol and cigarettes)?

_____
_____
_____

How often do you use these substances (if not currently using, how often in past)?

_____
_____
_____

Do you consider any of your substance use to be a problem? _____ Yes _____ No
If yes, please describe:

_____
_____

Are you having any problems with your sleep habits? _____ Yes _____ No

(If yes, circle where applicable)

Sleeping too little Sleeping too much Poor sleep Disturbing dreams Other

Use this space to describe sleep issues:

_____

_____

How many times a week do you exercise? _____

For about how long each time? _____

What type of exercise do you do?

_____

Do you have any ongoing health issues? If so, what are they?

_____

_____

Have you ever been hospitalized? If so when and for what?

_____

_____

Are you having any difficult with appetite or eating habits? _____ Yes _____ No

(If yes, circle where applicable)

Eating less Eating more Binging Restricting Significant weight change

Do you have any problems or worries about sex? _____ Yes _____ No

(If yes, circle where applicable)

Lack of desire Performance Sexual Impulsiveness Maintaining arousal Other

What activities do you enjoy doing in your free time?

_____

_____

_____

Which of the following applies to you?

I am □_□Single □_□Married __ Partnered _□ Divorced _□ Widowed _□ Other

_____ I am in a serious relationship and we live together

_____ I am in a serious relationship and we do not live together

Please list previous marriages and/or serious relationships.

_____

_____

_____

Please answer the following if you are with a partner now:
What is your partner's name?

_____

What is your partner's occupation?

_____

Please list the names and ages of your children, if any, including step-children.
Please note if your children are biological or adopted. If adopted, please note the age they were adopted. If any of them are deceased, please list date they passed:

_____
_____
_____

FAMILY BACKGROUND

Has Child Protective Services ever been involved in your life? If so, when and why?

_____
_____

Do you have any current involvement with the legal system? If so, why?

_____
_____

Please list the members of your current family, including ages and occupations.
Please be sure to state if family members are biological, adoptive, or other

_____
_____
_____
_____

Please circle any past or impending issues that apply to you, your parents and/or siblings?

	Self	Mother	Father	Sibling(s)
Alcohol abuse				
Drug abuse				
Emotional problems				
Psychiatric				
Hospitalizations				
Anxiety				
Depression				
Other mental illness				
Ulcers or colitis				
Asthma				
Serious physical illness				

Weight/eating problems
Anorexia
Bulimia
Insomnia
Attempted/ completed
Suicide
Epilepsy
Physical Abuse
Sexual Abuse
Injuries/disabilities
Childhood
Illnesses
Frequent relocations
Learning problems
Deaths
Divorce
Financial
Crisis/unemployment
Legal problems
Other

Are your parents married or divorced? _____

If Divorced, are either of them re-married?

_____

_____

Who are your main supports?

_____

_____

What are your strengths?

_____

What parts of your life do you enjoy?

_____

Any health issues, allergies, hospitalizations?

_____

_____

Please state in detail your present issues, how long they have persisted, and your reason for seeking therapy at this time (use as much space as you like. Feel free to write on back of this page). Thank you.