

Adult Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(First) (Last)

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male Female

Marital Status:
Never Married Domestic Partnership Married Separated
Divorced Widowed

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () May we leave a message? Yes No

Cell/Other Phone: () May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

Would you like me to send you my e-newsletter? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services as a child or adult (psychotherapy, psychiatric services, etc.)?

No

Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

Yes

No

Please list: _____

—

Have you ever been prescribed psychiatric medication?

Yes

No

Please list and provide dates:

—

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. Please list any difficulties you experience with your appetite or eating patterns.

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4. Are you currently experiencing overwhelming sadness, grief or depression?

No

Yes

If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias?

No

Yes

If yes, when did you begin experiencing this? _____

6. Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe? _____

7. Do you drink alcohol more than once a week? No Yes

3. What do you consider to be some of your weakness?

4. What would you like to accomplish out of your time in therapy?
