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Adult Intake Form

Contact information

Name:_____

Address:_____
(Street) (City) (State) (Zip code)

Home number:_____ Can I leave voicemail: ☐ Yes ☐ No

Mobile number:_____ Can I leave voicemail: ☐ Yes ☐No

Email address:_____

Preferred method of communication:_____ Referred by:_____

Personal Information

Dob:_____ Age:_____ Gender:_____

Occupation:_____ Employer: _____

Relationship Status: ☐ married ☐ single ☐ domestic partnership ☐ separated ☐ divorced
☐ widowed ☐ Other: _____

If married/partnered:
Name of partner/spouse:_____ How long have you been together: _____

Do you have children: ☐ Yes ☐ No Please list names/ages:_____

Presenting Problem

Reason for coming: _____

_____

Emergency Contact Information

Name: _____ Relationship to you: _____

Address: _____
(Street) (City) (State) (Zip code)

Phone: _____ Email: _____

Medical History

Primary Care Physician:_____ Phone Number:_____

Have you had prior psychotherapy? ☐ Yes ☐ No

- If yes, with who:_____ For how long:_____
- For what concerns: _____

Have you ever been prescribed any psychiatric medications? ☐Yes ☐No

- If yes what medications:_____

List any medical problems: _____

Please list current medications: _____

Allergies: _____

How often do you drink alcohol and how much do you typically drink? _____

Do you smoke cigarettes (if yes how often)? _____

Do you have any concerns about your use of alcohol or drugs? ☐ Yes ☐ No

- If yes please describe:_____

Family Health History

Family history of mental health: _____

Family history of medical concerns: _____