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**Adult Intake Form**

Date___________________

Name ______________________________________ Date of Birth ___________________ Birth Time ______

Address ____________________________________________________________ Phone _______________

Emergency Information

Emergency Contact Name and Phone number________________________________________________________

Relationship to you ___________________________________________________________________________

Medical /Psychiatric Conditions to be aware of ______________________________________________________

Medications – Names, Reasons Prescribed, Dosages, Prescribing Doctor

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Current Employment _______________________________ Position __________________ How Long ______

Source of Income _____________________________________________________________________

Family History

Marital Status ________________________ Year married / divorced _________________________

Are you co-parenting with an ex? ______________________

Other family members – please specify if they are living in your home

| Name | Age | Relationship |
| --- | --- | --- |
| ____________________________ | ____________ | _____________________________ |
| ____________________________ | ____________ | _____________________________ |
| ____________________________ | ____________ | _____________________________ |
| ____________________________ | ____________ | _____________________________ |

Are there or has there been any of the following for you or your family members? If so please check and specify who it relates to :

Alcohol/Drug Use or Abuse _______

Serious/Chronic Illness or Accident _____

Suicide _____

Mental Illness _____

Child Abuse _____

Domestic Violence _______

Legal / Law Problems _____

Learning Disabilities _____

Sexual Abuse _____

Death of a Family Member _____

Other trauma ______ (if yes, please describe) ________________________________________________________

Any significant issues during pregnancy / early childhood ______________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Identified Strengths and Problem(s)

What are your strengths? ________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What are the reasons you seek therapy at this time : ____________________________________________

________________________________________________________________________________

________________________________________________________________________________

Have you been in therapy before? How was the experience successful? How could it have been better?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Goals – What changes in your life would you like to see as a result of psychotherapy at this time:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________