Confidential Intake Form for Adults

Please take some time to complete this form to provide me some information about yourself and your reasons for seeking therapy services. Please bring this completed form to your intake appointment. I will likely ask you to complete additional questionnaires about specific problems you are experiencing. Taken together, in addition to the information you provide me in your intake appointment, this information will inform whether or not we are a good treatment match and if so, the elements we will include in your tailored treatment plan.

Today's Date: _____

I. CONTACT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: ___ Gender: ___

Address: _____

_____

Home phone: _____ Cell Phone: _____ Other phone number: _____

May I call and leave a message on all numbers listed above? _____

If you would like to use email for scheduling, please list your email address: _____

Emergency Contact (name, phone, relation): _____

_____

Occupation and employer: _____Marital Status: _____

How did you learn about my practice? _____
May I thank this person (if person referred)? Yes___ I'd prefer that you don't___

II. REASONS FOR SEEKING SERVICES

Please describe in a few sentences your main reasons for seeking services

_____

_____

_____

Please check all of the following items that are concerns at this time:

_____ Abuse Emotional, physical, verbal, sexual, neglect
_____ Academic or work issues
_____ Aggression/violent behavior
_____ Alcohol or drug use
_____ Anxiety, nervousness
_____ Body image
_____ Career concerns, choices
_____ Caregiver/multiple role stress
_____ Childhood issues (yours)
_____ Children/parenting concerns
_____ Compulsive behaviors
_____ Concentration, Decision making, indecision
_____ Grief issues
_____ Depression, sadness, crying
_____ Divorce, separation
_____ Eating problems
_____ Family relationships
_____ Fears, phobias
_____ Fertility difficulties
_____ Financial problems
_____ Gambling
_____ Guilt
_____ Health, medical concerns
_____ Hallucinations
_____ Identity issues

_____ Legal problems
_____ Loneliness, withdrawal, or isolation
_____ Mood swings
_____ Motivation issues
_____ Panic attack
_____ Pregnancy related concerns
_____ Repeated troubling thoughts
_____ Relationship concerns
_____ Self-injury, mutilation
_____ Self-neglect, poor self-care
_____ Sexual assault
_____ Sexual concerns
_____ Sexual orientation/identity
_____ Sleep problems
_____ Stress
_____ Suicidal thoughts
_____ Violent thoughts

III. RELEVANT HISTORY

PREVIOUS PSYCHOLOGICAL TREATMENT. Please list all past psychological treatment, including any hospitalizations; including reasons, location, and timeframe.

_____

_____

_____

Name and number of provider who is currently prescribing you any medications for your mood or mental health symptoms, if applicable:

_____

Please list any current psychiatric medications you are taking and reason they are prescribed:

_____

Psychiatric medications taken in the past, if applicable:_____

_____

_____

MEDICAL HISTORY: Please list any significant medical history (e.g., chronic conditions, accidents, major illnesses, surgeries):

_____

_____

Please list any current medical problems: _____

_____

Other current medications: _____

Name of Primary Care Provider: _____ Phone Number:_____

FAMILY HISTORY:

1) Medical problems in family (parents, spouse/partner, children)? yes no unsure

If so please list: _____

2) Emotional/psychiatric problems in family members? yes no unsure

If so please list: _____

3) Familial history of suicide attempt or psychiatric hospitalization? yes no unsure

If so please list: _____

4)) History of alcoholism/substance abuse in family? yes no unsure

If so please list: _____

IV. FINANCIAL INFORMATION

_____ _____
Name of Person Responsible for Account Relationship to Client

_____ _____
Street Address City State Zip

_____ _____
Home Phone Work Phone

Do you have health insurance: _____ If so, name of insurance provider: _____

Client's Signature _____ **Date** _____