

Adult Intake Form

Please complete all sections, print, and bring it with you to your appointment.

1 | CLIENT INFORMATION

First Name

Last Name

Date of Birth

 / /

Age

Sex

☐

Male

☐

Female

☐

Prefer not to disclose

Height

Weight

Hair Color

Eye Color

Street Address

City

State

Zip Code

County

Mobile Phone Number

Alternate Phone Number

Email Address

2 | INSURANCE INFORMATION

Provider/Insurance Company Name

Cardholder Name

Cardholder Date of Birth

 / /

Member ID Number

3 | FAMILY INFORMATION

Household Members

Please list all those who live in your home with you.

Name	Age	Relationship

Number of Brothers

Number of Sisters

Parents

Mother

☐ Alive ☐ Deceased

Father

☐ Alive ☐ Deceased

Do you maintain contact with any of your siblings? ☐ Yes ☐ No

If so, please describe with whom and how often

Marital Status

☐ Married
 ☐ Never Married
 ☐ Separated
 ☐ Divorced
 ☐ Widowed

Do you have any children? ☐ Yes ☐ No

If yes, how many

Names and ages of your children:

Name

Age

4 | EDUCATIONAL BACKGROUND

Name of High School Attended

Graduated from High School? ☐ Yes ☐ No

If not, in what grade did you leave school?

☐ 7
 ☐ 8
 ☐ 9
 ☐ 10
 ☐ 11
 ☐ 12

GED? ☐ Yes ☐ No

History of Special Education? ☐ Yes ☐ No

If yes, what type of Special Education?

☐ Learning Support
 ☐ Emotional Support
 ☐ Other

If Other, please specify

Vocational Training? ☐ Yes ☐ No

If yes, what did you study?

College or University? ☐ Yes ☐ No

If yes, where did you attend?

Graduated? ☐ Yes ☐ No

Degree Earned?

Advanced Degree? ☐ Yes ☐ No

Degree(s) Earned?

Military Service? ☐ Yes ☐ No

Branch

Total Years of Military Service

Current Occupation

How Long in Current Role

How Long in Prior Role

Anything additional you wish to share concerning your work life?

5 | HEALTH / MEDICATION / MENTAL HEALTH HISTORY

Any previous mental health diagnoses? ☐ Yes ☐ No

If yes, please list all prior diagnoses

Medications & Dosages (for mental health treatment)

Name

Dose

Who prescribes/prescribed the medication?

PCP (Primary Care Physician) Name

Practice Name

PCP / Practice Phone Number

6 | CURRENT MEDICAL CONDITIONS

Please check all that apply.

☐ Allergies (list all)

☐ Asthma

☐ Seizures

☐ Hearing deficits (hearing aid)

☐ Vision deficits (glasses)

☐ Head injury / Concussion

☐ Traumatic Head Injury (TBI)

☐ Other serious medical conditions

If Allergies or Other, please specify

Please describe any bodily aches, pains, conditions, or diseases

Have you received any prior mental health services? ☐ Yes ☐ No

If yes, please describe

Are you currently receiving mental health services? ☐ Yes ☐ No

If yes, please specify the type of services (outpatient counseling, medication, etc.)

Group or agency providing your current mental health services

Please describe any mental health history in your immediate and/or extended family

7 | PRIMARY CONCERNS

Please check all that apply.

- ☐ Depression (sadness, no motivation, no energy)
- ☐ Mood swings
- ☐ Panic attacks (intense anxiety, sweating, dizziness)
- ☐ Obsessing on things
- ☐ Argue with others
- ☐ Poor sleep
- ☐ Flashbacks

- ☐ Anxiety (nervous all the time, worry)
- ☐ Very uncomfortable in social situations
- ☐ Compulsive behaviors
- ☐ Difficulty taking orders from bosses/supervisors
- ☐ Temper outbursts
- ☐ Nightmares
- ☐ Medical/physical problems (chronic pain, no energy, easily fatigued)

- | | |
|--|---|
| ☐ Vision problems | ☐ Hearing problems |
| ☐ Can't read or write | ☐ Trouble learning |
| ☐ Alcohol abuse | ☐ Substance abuse (cocaine, heroin, marijuana) |
| ☐ Hearing voices others can't hear | ☐ Poor concentration |
| ☐ Poor memory | ☐ Easily distracted (can't pay attention) |
| ☐ Can't sit still (always fidgety and moving) | ☐ History of incarceration |

Other (please describe)

All Done!

Please print this completed form and be sure to bring it with you to your appointment.
We look forward to serving you.