**Intake Form – Adult, Individual Therapy**

| First Name | Last Name | | | Today's Date |
|---|---|---|---|---|
| Birth Date / / | Age | Gender | Sexual Orientation | |
| Cell Phone | Ok to leave message? Yes No | Home Phone | Ok to leave message? Yes No | Work Phone Ok to leave message? Yes No |
| Street Address | City | State | Zip | |
| Email address | | | May I email you? Yes No | |
| Relationship Status (circle all that apply): Dating Married Living Together Living Apart Separated Divorced | | | Length of relationship: _____years, _____months | |
| Emergency contact: (name, number, relationship to you) | | | | |
| Referred by (if any): | | | | |

**Please provide the following information about your children and household.**

| Child | Sex | Age | Name (Optional) | If the child is not a product of your current relationship, please list details (i.e., adopted, foster child, one partner's child from another relationship, etc.) |
|---|---|---|---|---|
| 1st | M F | ____ | _____ | _____ |
| 2nd | M F | ____ | _____ | _____ |
| 3rd | M F | ____ | _____ | _____ |
| 4th | M F | ____ | _____ | _____ |
| 5th | M F | ____ | _____ | _____ |

Who lives in your house with you?

_____

What do you do for work?

_____

**Please describe any current or previous experiences with counseling or therapy services.**

| Name of Counselor/Agency | Reason for seeking counseling | Approximate dates | Helpfulness of counseling *None* | *Somewhat* | *Very* |
|---|---|---|---|---|---|
| _____ | _____ | _____ | 1 | 2 | 3 |
| _____ | _____ | _____ | 1 | 2 | 3 |
| _____ | _____ | _____ | 1 | 2 | 3 |

**Do you drink alcohol or use drugs recreationally?**
If yes, how often and what drugs or alcohol?
_____
_____
_____

**Have you ever received help for drug or alcohol dependency?**
If yes, when? _____ For what?_____
Where?_____

**Have you ever been hospitalized for mental/emotional/psychiatric reasons?**
If yes, when? _____ For what? _____
Where?_____

**Have you ever attempted suicide?**
If yes, how many times, how, and when?_____
_____
_____

**Are you currently taking prescribed psychiatric medication (anti-depressants, etc)?**
If yes, what medication, and prescribed by whom?
_____
_____
_____

**Are you currently suffering from general medical conditions, sleeping/eating problems, chronic pain, or depression/anxiety?**
If yes, what symptoms are you experiencing?
_____
_____
_____

**Please share any relevant family history of mental health concerns:**
_____
_____
_____

| Signature | Date |
|---|---|
| | |