CONFIDENTIAL ADULT INTAKE FORM

Date_____

Personal Information

Name: _____

Street /address _____

City, State, Zip: _____email address_____

Home/ Business/Cell phone #'s _____

Education (years completed, trade school or college) _____

Employer: _____ _____
Social Security Number:
Occupation: _____

Date of Birth: _____ Age _____ Male/Female _____

Religious Affiliation: _____

Married___ Single ___ Domestic Partner ___ Divorced ___ Separated ___ Widow(er)__

If married or DP: Date of current marriage/DP: _____ Number of years _____

Spouse/Partner Name _____ Age _____ Education _____

Spouse/Partner Employer _____ Occupation _____

If divorced: date of divorce: _____ Number of years married _____

Children:

Name	Age	School Grade	Live in home?
_____		_____	_____
_____		_____	_____
_____		_____	_____

Name of Insurance:_____ ID# _____ Group# _____
Phone number for Providers:_____

Who is currently living in your household? _____

Medical and Counseling Information

Please describe any previous counseling and/or psychiatric care, including approximate dates, length of treatment, and primary purpose of treatment: _____

_____

Doctor or therapist: _____

History of any of the following (please check all that apply):

____Alcohol or substance abuse ____Suicide attempt

____Sexual Abuse ____Physical Abuse

____Depression ____Severe Anxiety/Panic Attacks

____Domestic Violence ____Anger Management Problems

Do you drink alcohol? If yes, how often and how much? _____
Do you smoke cigarettes? How often?__
Do you use drugs? How often and what? _____

Other additional comments: _____

Family physician: _____

Date of last doctor's visit: _____

Current medications: _____

Chronic Medical Problems: _____

Please briefly describe the reasons you are seeking assistance at this time.

_____

_____

_____