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ADULT CLIENT INTAKE

Today's Date: _____

Client: _____ **Birth Date:** _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____

Education: _____

Marital Status: _____

Partner / Significant Other: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____

Children and their ages: _____

Who lives in your home? _____

Referred by: _____

MEDICAL HISTORY

Any illness or major injuries or surgeries?

Any allergies? _____

Primary care provider: _____

Date of last physical: _____

Medication(s), including dosage: _____

Prescribed by _____

Please indicate amount and frequency of use, if applicable:

a. Alcohol: _____ c. Caffeine: _____

b. Tobacco: _____ d. Illicit Drugs: _____

Past Hospitalizations: Medical, Psychiatric, Chemical Dependency:

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Psychotherapy

<u>Facility/Therapist's Name</u>	<u>Dates Seen</u>	<u>Helpful or Not Helpful</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any additional previous strategies tried? (e.g. meditation, yoga, books, etc).

FAMILY HISTORY

Describe any psychiatric problems, drug abuse, or alcoholism in immediate family and extended family:

Support systems: (e.g., extended family members, community agencies, religious institutions, etc).

What concerns bring you to this office?

What changes do you want to see?

ADDITIONAL REMARKS: Please use the back of this page or add a page to provide any additional comments you wish to make regarding your difficulties.