Alvord | Baker & Associates, LLC
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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:

Date	Reason	Hospital

Previous Psychotherapy

Facility/Therapist's Name	Dates Seen	Helpful or Not Helpful

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.