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Intake Form for Adults

Today's Date: _____ Name_____
Your age _____ Date of Birth _____ Gender_____
Address
_____
_____
Email address_____ Cell Phone_____
Occupation (s)
_____
Who referred you to therapy?
_____
Have you had prior experience in counseling? Yes ( ) No ( ) If yes, please describe with whom, when, how long, and for what:
_____
_____
_____
Please rate your general satisfactions with life a present (circle one) Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied
What are the three most significant issues you face currently?
1.
_____
2.
_____
3.
_____
Present Marriage (or significant relationship)
Spouse/Partner _____ Age ____ Gender _____
Occupation_____ Years known each other _____ Years married____
Date married _____
Children of this marriage (names/ages) Stepchildren (names/ages)
_____
_____
_____
Have you been married before? ____ If one or more prior marriage(s), please list below (use back of page if more space is needed):
_____
_____

Please rate your level of satisfaction in present marriage/significant relationships
Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied
Family of Origin (Parents & Siblings)
Parents still together _____ Divorced _____ Remarried _____
Mother's name _____Age _____ Occupation _____
Present state of health _____
If deceased, year/cause
_____
Father's name _____ Age _____ Occupation _____
Present state of health
_____
If deceased, year/cause
_____
Step parents
_____
_____
Siblings (Biological and Step): Age, Marital Status, Occupation, Location
_____
_____
_____
_____
How would you rate relationships with your parents generally? (Scale 1-10) 1 = non-existent & 10 = "best of friends"

Mother: ____ Step-mother: ____ Father: _____ Step-father: _____
Extended and Immediate Family history (please check those which apply and to whom) Divorce ___ Alcohol/substance abuse ____ Physical abuse ____ Sexual abuse ____ Depression ___Anxiety ___ Suicide ___ Bipolar ___Mental illness (other) ____
Whom does this apply?
_____
_____
_____
Current/Recent Mood (check all that apply as of recently)
Anxiety ___ Fear ___ Sadness ___ Grief ___ Anger ___ Irritability ___ Happy ___ Impatient ___ Calm ___ Numb ___ Suicidal ___
Other_____
Any changes or concerns involving the following? (Please check those which apply)
Finances ___ Legal Matters ___ Work/Job ___ Education/School ___ Moving ___ Marital Status ___ Parenting ___ Concentration ___ Memory ___ Energy____

Health/Illness ___ Surgery/Injury ___ Grief/Loss ___ Addition of a Family Member ___ Family Member Leaving Home ___ Sexual Activity ___ Sleep Habits ___ Eating Habits ___
Caffeine Intake ___ Tobacco Use ___ Alcohol Use ___ Drug Use ___ Other _____

Years & Level of Education:
_____

Is Spirituality/Religion important to you?
_____

Do you attend (or have you attended) any Self-Help Groups? Yes ( ) No ( )
_____

Who do you consider as your greatest support?
_____
_____

What do you consider your greatest strengths?
_____
_____

What do you consider your greatest weakness?
_____
_____

How do you rate relationship with yourself generally? (Same scale as above) _____

Why:_____
_____
_____

Is there anything in particular that you want me to know about you or your situation?
_____
_____
_____
_____
_____
_____

Thank you and I look forward to working with you.