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Adult Intake: Please complete the following information, as it will help me in planning and providing appropriate services for you.

Name: _____ Date: _____
Address: _____ City: _____ Zip:_____
Home phone: _____ Cell phone:_____
E-mail address: _____
Date of Birth: _____Age: _____ Referred by:_____
Occupation or student: _____Work phone:_____
Place of employment or school:_____
Which phone number do you prefer to be contacted on? _____
Relationship status: _____Previously Married? _____
Please list all other family members or others living in your home:

Name(s)	Age	Relationship

Emergency contact (name, phone, relationship): _____
_____
Physician (name, phone, address): _____
_____
Have you ever been diagnosed with a serious illness? If yes, please describe: _____
_____
Please list any health/medical conditions for which you are receiving treatment:

Do you have allergies or asthma? _____
Please describe your overall health today: _____
_____
Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe:_____
Do you smoke? If yes, how much?_____
Do you drink alcohol, If yes, how much/often?_____
Do you take drugs? If yes, what kind and how often: _____
Please list any medications you are taking: _____
Please list any medications you have taken in the past:_____
_____

Have you been in therapy, or had psychiatric help of any kind in the past? If yes, please describe:_____
Have you ever attempted suicide? If yes, please describe:_____
_____
Briefly describe concerns which brought you to therapy: _____
_____

Please check any of the following areas in which you are having difficulty:

_____Headaches _____Sadness _____ Anger _____Dizziness _____ Obsessions
_____Aggression _____Isolation _____Fainting _____Compulsions _____Relationship issues
_____Nausea _____Loneliness _____Anxiety _____Trauma _____Always tired
_____Decreased appetite _____Racing thoughts _____Hopelessness _____Hyperactivity
_____Increased appetite _____Sexual dysfunction _____Fatigue _____Frequent urination
_____Impulsivity _____ Tics _____Insomnia _____Bowel disturbance _____Elevated mood
_____Increased sleep _____Hallucinations _____Mood swings _____Nightmares
_____Paranoia _____Hearing voices _____Panic attacks _____Anorexia/Purging
_____Suicidal thoughts _____Suicidal actions _____Cutting _____Homicidal thoughts
_____Feel like crying _____Can't keep friends _____Feel tense _____Distrust of others
_____Financial problems _____Lack of interest _____Feel worthless _____Blurred vision
_____Flashbacks _____Stomach trouble _____Conflict with family/children
_____Recent weight gain/loss _____Excessive checking, list-making, washing
_____Smelling things others don't smell _____Decrease need for sleep
_____Verbal, emotional, physical, sexual abuse _____Victim of Violent Crime

Please add anything you think it would be important for me to know about you:_____
_____
_____
_____
_____