# Adult Intake

Date: _____

## Client and Insurance Information:

Name of Client: _____
Home Address: _____ City: _____State: _____
Zip Code: _____ Home phone: _____
Work Phone: _____ Cell Phone: _____
Email Address: _____
Can messages be left at the numbers listed above? _____
Social Security Number: _____
Date of Birth: _____ Age: _____ Sex: Male Female
Marital Status: _____

Insurance Holder Name: _____ DOB: _____
Insurance Holder's Address: _____
Insurance Company: _____
Policy Number: _____
Insurance Holder Place of Employment: _____
Deductible: _____ Copay: _____ Auth: _____
Is there Secondary Insurance? _____

Referred by: _____

## Presenting Problem:

Describe the problem you are having and when it started:

## Social History:

Place of Birth: _____
Where did you grow up? _____
Did your family move around? If yes, please describe:

How many siblings do you have?

Describe your childhood?

Were you ever abused (physically, sexually, emotionally)?

Who do you rely on for emotional support?

Have there been major losses, changes or crises in your life? If yes, please describe.

Do you have any type of belief system (moral, spiritual, cultural, religious) that influences our life?

## Educational History:

What is the highest grade you completed?

Did you receive any special education services?

How did you get along with your teachers and your peers?

Did you have any discipline problems at school?

## Military History:

Did you or do you serve in the military? _____ Yes _____ No
What branch and dates of service?

Were you stationed in a combat or other high-risk zone?

Type of discharge:

## Occupational History:

Are you currently employed? _____ Yes _____ No
Where do you work?

How long have you been there?

What is your current position?

Do you like your job?

Are there any current job stressors you are experiencing?

Have you ever been laid off or fired?

Do you get along with your co-workers?

## Relationship History:

What is your marital status? _____ Single _____ Married _____ Divorced
_____ Widowed _____ Separated _____ Other

Describe your current relationship, including any stressors:

Describe any prior marriages or long-term relationship and the reason for the divorce/break up:

List any child you have, including their names and ages:

Please describe any problems with your children:

List all people currently residing in your home:

## Medical History:

List any hospitalizations/surgeries you have had:

Current Medications, including who prescribes them and what they are for:

| Medication | Dosage | Date Started | Prescribed by | Condition presribed for |
|---|---|---|---|---|

Please list any allergies:

Have you ever of do you current use alcohol or drugs?

Family history of medical problems:

## Risk Assessment:

| | **Past** | **Now** |
|---|---|---|
| Have you ever had thoughts of hurting yourself? | _____ | _____ |
| Have you ever had thoughts of committing suicide? | _____ | _____ |
| Have you ever had a plan to commit suicide? | _____ | _____ |
| Have you made threats to kill yourself? | _____ | _____ |
| Have you ever made a suicide attempt? | _____ | _____ |
| Have you ever mutilated yourself? | _____ | _____ |
| Have you ever had thoughts of harming someone? | _____ | _____ |
| Have you ever had plans to harm someone? | _____ | _____ |
| Have you ever attempted to harm someone? | _____ | _____ |
| Have you ever made threats to harm someone? | _____ | _____ |

Is there any additional information you feel would be helpful in your treatment?

_____ _____

Your Signature Date