



DATE: _____

ADULT INTAKE FORM

18+ YEARS OLD

This information is intended to assist our staff in working with you toward your goals of therapy. If you have any concerns about answering these questions, we encourage you to discuss them in person with our staff.

Information you provide here is protected as confidential with two exceptions: 1) All therapists and counseling office staff are mandated to report suspected child abuse or neglect, including information about yourself or children in your care, as well as information you may tell us about any physical, sexual, psychological, or emotional abuse of a minor by another individual. 2) We are mandated to take action if we believe you are a harm to yourself or to others.

Client Name: _____
(First) (Middle Initial) (Last)

Address: _____
(Street and Number)

(City) (State) (Zip)

May we send mail to the above address? Yes No

Cell/Other Phone: _____ May we leave a message? Yes No

Home Phone: _____ May we leave a message? Yes No

E-mail: _____

May we email you regarding appointment-related correspondence? Yes No

May we email you with occasional updates or information? Yes No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Birth Date: ____ / ____ / ____ **Age:** ____ **Gender:** Male Female Other: _____

Last 4 digits of your social security number: XXX-XX- _____

Client Ethnicity: *(This information will be used for classification purposes only)*

- African American (not of Hispanic origin) Asian or Pacific Islander
 Hispanic Native American or Alaskan Native White/Caucasian
 Bi/Multi-racial Other: _____

Client Marital Status:

- Minor (under 18 years old) Single, never married Married
 Separated Divorced/Single Divorced/Remarried
 Widow/Widower Domestic Partnership

How did you hear about us?

- Parent/relative Court/Police Friend School Online
 Insurance Agency Post Card Professional Other
 You're a returning client From someone who is/was a client

Name of referral source: _____

Have you served in the military? Yes No

Has a loved one (family or friend) ever served in the military? Yes No

If yes, please describe: _____

Emergency Contact Information:

By providing this information, you are giving us permission to call if there is an emergency.

Name: _____ Relationship: _____

Local phone number: _____

ADDITIONAL INFORMATION

1. Are you currently employed? No Yes

If yes, what is your current employment situation? _____

2. Are you currently a student? No Yes

If yes, what is your current school name? _____

Household Size

- 1
- 2
- 3
- 4
- 5
- 6
- Other: _____

Annual Gross Household Income

- Up to \$15,000
- \$15,001 to \$30,000
- \$30,001 to \$40,000
- \$40,001 to \$50,000
- Over \$50,000

Do you have medical insurance? Yes No

If Yes, Provider: _____

If paying with one of the insurances we currently accept, you will be asked to provide us with a **copy of your insurance card** and to complete Acknowledgement of Financial Responsibility and Release forms. Please note: if we do not accept your insurance and you intend to file for reimbursement with your insurance, you must notify us so we can ensure you are seen by a licensed therapist.



GENERAL PHYSICAL HEALTH AND WELLBEING INFORMATION

1. Current physical health, including specific health concerns, diagnoses, or treatment:

2. Current prescription medications:

3. Date of last medical exam: _____ **Family doctor:** _____

Phone: _____ **Address:** _____

4. Current sleeping habits, including specific sleep concerns:

5. Current chronic pain you are experiencing:

6. Current exercise and physical activities:

7. Current appetite or eating patterns, including specific eating concerns:

By signing below, I certify that all of the information provided within this form is true and correct to the best of my knowledge.

Client Signature

Date

FOR OFFICE USE ONLY:

Client #: _____

Classification: _____

Assigned Fee: _____

Counselor Assignment: _____