

ADULT INTAKE INFORMATION

Client's Name: _____ Today's Date: _____
Last First MI

Address: _____
Street or PO Box City State Zip Code

Mailing Address (if different) _____
Street or PO Box City State Zip Code

Your Age: _____ Date of Birth: _____ Social Security Number: _____

Contact Information:

Relationship Status:

Primary Phone #: _____
Secondary Phone #: _____
Employer: _____
Job Title: _____
Work Hours: _____
Work Phone: _____
Email Address: _____

Married: _____ Date: _____
Divorced: _____ Date: _____
Separated: _____ Date: _____
Widowed: _____ Date: _____
Committed Relationship: _____ Date: _____
Never Married: _____

Are there any restrictions on calling or leaving a message? Yes _____ No _____

What restrictions? _____

Spouse/Partner's Name: _____ Date of Birth: _____ Age: _____

Spouse/Partner's Home Phone (if different): () _____ Work Phone: _____

Spouse/Partner's Employment: _____ SS#: _____

Referred By?: _____

PRESENTING PROBLEM(S)

Briefly describe why you are here: _____

What do you want to accomplish as a result of your therapy here?: _____

Continued on other side

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Others in Household: Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

THERAPIST NOTES: _____

Whom may we contact in case of an emergency?: Name: _____

Phone #: _____ Relationship: _____

Physician's Name: _____ Phone #: _____

EDUCATIONAL HISTORY:

Presently enrolled in school? Yes ___ No ___ Highest grade completed? _____

MILITARY HISTORY:

Have you served in the armed forces? _____ Branch: _____
When: _____

THERAPIST NOTES: _____

