HIGH LEVEL

Counseling Center 407-668-6025

ADULT INTAKE FORM

Name:			
SS #:	**Age:**	**DOB:**	
Address:			
Telephone numbers:	**Home:**	**Work:**	**Cell:**
Can I leave a message at the above number?	**YES/NO**	**YES/NO**	**YES/NO**
Preferred way to be contacted (circle one):	**Home**	**Work**	**Cell**
May I contact you by E-mail? YES/NO		**Email:**	

Please include spouse/partner information if seeking couples/family therapy:

Name:			
SS #:	**Age:**	**DOB:**	
Address:			
Telephone numbers:	**Home:**	**Work:**	**Cell:**
Can I leave a message at the above number?	**YES/NO**	**YES/NO**	**YES/NO**
Preferred way to be contacted (circle one):	**Home**	**Work**	**Cell**
May I contact you by E-mail? YES/NO		**Email:**	

In case of an emergency, who may I contact on your behalf?

Name:	**Relationship:**
Phone Number:	**Address:**

If you have previously been married, please fill out the following section:

	Date began:	**Date ended:**	**Ex Spouse name**	**Children**
1st Marriage				YES/NO
2nd Marriage				YES/NO
3rd Marriage				YES/NO

Family of Origin: List parents, siblings, step family, and any other significant family members. If seeking couples/family therapy please indicate *both* partners family of origin information. If person is deceased put an "X" in the age box and indicate date of death.

Name	Age	Relationship	City, State

Children: (List all children, including biological, adopted, foster, and step children)

Name	Age	Relationship	City, State	Lives at home?
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO

Relationship Status: (Circle all that apply)

Single	Married	Divorced	Separated
Widowed	Remarried	Long-term Relationship	Cohabitating

Current partner's name:	**Partner's Occupation:**	**Length of Relationship:**
How satisfied are you with your current relationship (on a scale from 1-10)? (very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)		
What is your occupation?	**Employer:**	
Do you enjoy your occupation: YES/NO	**Average hours worked per/week:**	

Highest level of education:	Highschool	Some college	College degree	Graduate School	Other
If you received a college/graduate degree, what was your degree in?					
If you are currently a student, what are you studying?					
How would you describe your spiritual or religious beliefs?					

Have you ever received or given abuse: YES/NO	**If yes please circle type:** Physical Emotional Sexual Neglect Other

Do you have a primary care physician? YES/NO	**Physicians name:**
Are you under the care of a psychiatrist? YES/NO	**Psychiatrists name:**

Are you under the care of a specialist? YES/NO					
If yes, please circle type of specialist:					
Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility	Nephrologist
Neurologist	Nutritionist	Occupational Therapist	Oncologist/ Hematologist	Orthopedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Please list any chronic illness, disabilities, or medical conditions that you have been diagnosed with:

Illness/Disability	Dates

List all medications you are currently taking:

Medication	**Dosage**	**Treating**
Are you taking the medications according to your doctor's recommendation? YES/NO If No, briefly explain:		

Average number of hours you sleep at night?	**How long does it take for you to fall asleep?** ____ min. ____ hrs.
Do you wake up in the night? YES/NO	**If yes, how often**? _____ times per night.
How would you rate your overall sleep at the present time? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	
Do you exercise on a regular basis? YES/NO **If yes how often?** ____ times per week.	
If yes, please briefly describe activity:	
How would you rank your overall diet on a scale from 1-10? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	

Do you drink alcoholic beverages? YES/NO	**If yes how many alcoholic beverages do you drink** ____ weekly ____ daily
Do you think you have a drinking problem" YES/NO	**Does anyone else think you have a drinking problem?** YES/NO
Do you smoke? YES/NO	**If yes, how many cigarettes/packs do you smoke?** ____cig./day ____ packs/day
If yes, when did you start smoking?	**Have you ever tried to quit?** YES/NO
Have you in the past or currently: used, abused, or experimented with illegal drugs? YES/NO	**If yes, briefly explain:**

Have you ever attempted/seriously contemplated suicide? YES/NO
If yes, describe briefly and indicate dates:
Have you ever had a psychiatric hospitalization?
YES/NO **If yes, describe briefly and indicate dates:**

Therapy Experiences and Expectations:

Are you currently seeing another therapist? YES/NO
If yes, please indicate the therapist's name:
Have you ever been in therapy in the past? YES/NO
If yes, please fill out the following on your previous counseling experience(s):

Therapist	**Location**	**Dates**	**Reason for therapy**

Briefly describe your reason(s) for seeking therapy at this time:

What goals do you wish to accomplish during the therapy process?

Is there anything else you would think would be important for me to know about you and your family?

How were you referred to our office?