Adult Individual Intake Form

Full Name ______________________________________ Today's Date ________________

Address ____

City ____________________________ State __________ Zip Code __________________

Phone (home) _________________________ Phone (cell) ____________________________

Phone (work) _________________________ Email _________________________________

Preferred way to be contacted: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Mail

Can I leave a phone message? ☐ Yes ☐ No Can I send a text? ☐ Yes ☐ No

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Relationship Status:
_____ Single
_____ Dating
_____ Engaged
_____ Married/Living with Partner
_____ Separated
_____ Divorced
_____ Widowed
_____ Single Parent
_____ Other: __________________

Age: _______

Birthdate: ____________________

Gender:
_____ Male
_____ Female
_____ Other: ___________________

Ethnic/Racial Origin:
_____ Asian / Asian-American
_____ Black / African-American
_____ Caucasian / White / Euro-American
_____ Latino/a / Hispanic (Please specify: ___________)
_____ Middle Eastern
_____ Native American / Indian
_____ International
_____ Biracial / Multiracial (Please specify: __________
_____________________________________)
_____ Other: Please specify: _____________________
_____ I would not like to disclose

Referring Person/Agency: _________________________

Previous Counseling/Therapy Experiences:
_____ None
_____ Therapist: (Dates) ________________________
_____ Agency: (Dates) __________________________

Spiritual / Religious Affiliation:

☐ Catholic ☐ Protestant ☐ Muslim ☐ Hindu ☐ Buddhist ☐ Jewish ☐ Atheist ☐ Islamic

☐ Mormon ☐ Baptist ☐ Episcopalian ☐ Lutheran ☐ Methodist ☐ PCA/PCUSA ☐ Mennonite

☐ Chinese Traditional ☐ Non-Denominational ☐ Other: ______________________________

☐ I would not like to disclose

Are you currently practicing your religion / spirituality? ☐ Yes ☐ No ☐ I would not like to disclose

Please list any medications you are currently taking and what they treat:

____

____

Please list any other drugs you are currently taking (including recreational):

____

____

Please list any medical issues you are currently receiving treatment for:

____

____

Please provide information about your family:

	Name	Occupation	Alive/Deceased	Age
Parent(s)				
Step-Parent(s)				
Sibling(s)				
Partner/Spouse				
Children				
Other				

In case of emergency:

Local friend/relative (please have one not living with you) Relationship Phone No.

1. ____________________________________ ______________ ____________

2. ____________________________________ ______________ ____________

What would you like to accomplish in therapy?

1. ____

____

2. ____

____

3. ____

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