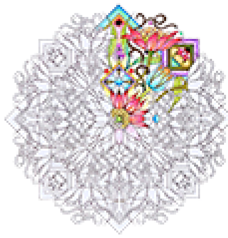

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Intake Form for Adults

Today's Date: _______________ Name____
Your age ___________ Date of Birth ________________ Gender____________________

Address ____
Email address____________________________ Cell Phone __________________________

Occupation (s) ____

Who referred you to therapy?

____

Have you had prior experience in counseling? Yes ( ) No ( ) If yes, please describe with whom, when, how long, and for what:

____
____

Please rate your general satisfactions with life a present (circle one)

Very dissatisfied **0 1 2 3 4 5 6 7 8 9 10** very satisfied

What are the three most significant issues you face currently?

1. ____
2. ____

3. ____

Present Marriage (or significant relationship)

Spouse/Partner _______________ Age ____ Gender ______ Occupation______________
Years known each other _____ Years married____ Date married ________
Children of this marriage (names/ages) Stepchildren (names/ages)

____

____

Have you been married before? ____ If one or more prior marriage(s), please list below (use back of page if more space is needed):

____

____

Please rate your level of satisfaction in present marriage/significant relationships

Very dissatisfied **0 1 2 3 4 5 6 7 8 9 10** very satisfied

Family of Origin (Parents & Siblings)

Parents still together ______ Divorced ________ Remarried __________

Mother's name _________________Age _____ Occupation ___________________________
Present state of health____
If deceased, year/cause ____

Father's name _________________ Age _____ Occupation ____________________________
Present state of health ____
If deceased, year/cause ____

Step parents

____

____

Siblings (Biological and Step): Age, Marital Status, Occupation, Location

____

____

____

How would you rate relationships with your parents generally?
(Scale 1-10) 1 = non-existent & 10 = "best of friends"

Mother: ____ Step-mother: ____ Father: _____ Step-father: _____

Extended and Immediate Family history (please check those which apply and to whom)
Divorce ___ Alcohol/substance abuse ____ Physical abuse ____ Sexual abuse ____
Depression ___Anxiety ___ Suicide ___ Bipolar ___Mental illness (other) ____

Whom does this apply?
____
____
____

Current/Recent Mood (check all that apply as of recently)

Anxiety ___ Fear ___ Sadness ___ Grief ___ Anger ___ Irritability ___ Happy ___ Impatient ___ Calm ___ Numb ___ Suicidal ___
Other____

Any changes or concerns involving the following? (Please check those which apply)

Finances ___ Legal Matters ___ Work/Job ___ Education/School ___ Moving ___
Marital Status ___ Parenting ___ Concentration ___ Memory ___ Energy____
Health/Illness ___ Surgery/Injury ___ Grief/Loss ___ Addition of a Family Member ___ Family Member Leaving Home ___ Sexual Activity ___ Sleep Habits ___ Eating Habits ___

Caffeine Intake ___ Tobacco Use ___ Alcohol Use ___ Drug Use ___ Other _______________

Years & Level of Education: ____ Is Spirituality/Religion important to you? ____ Do you attend (or have you attended) any Self-Help Groups? Yes ( ) No ( ) ________________ Who do you consider as your greatest support?_______________________________________
What do you consider your greatest strengths? _______________________________________
What do you consider your greatest weakness? _______________________________________

How do you rate relationship with yourself generally? (Same scale as above) _______________
Additional comments:____
____

Is there anything in particular that you want me to know about you or your situation?
____
____

Thank you and I look forward to working with you.
Kristen Miciotto