ADULT INTAKE FORM

Name:			
Gender:	**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:**

Primary Presenting Issue (s)

Summary of Previous Treatment/Testing

Comments on Medications

Other Medical Concerns/ History:

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:

Mood Issues/ Social Functioning

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:

Substance Use/Abuse

Family Issues/ History (background)

Relationship Status: (Circle all that apply)

Single	Married	Divorced	Separated
Widowed	Remarried	Long-term Relationship	Cohabitating
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)			

Profile of Patient

Academic and/Vocational History/Issues:

Areas of Interest/ Enjoyment

How would you describe your spiritual or religious beliefs? How does Faith play a role in your coping?

Legal History/Issues?

Stated Goals for Therapy?

Other Relevant Data (anything else you wish for me to know)