Adult Intake Form

The information asked is to help understand your situation, and to enable me to be of help to you. Please fill out this form as completely as you can.

Name_____
Last First Middle

Address_____
Street City State Zip

Number you prefer to receive calls _____

Email _____

Birth Date _____Age _____Gender _____ Marital Status_____

Place of Employment _____

Occupation_____

Referral Source _____

Medical:

1. Check the diseases/medical conditions you have had, indicating approximate age at the time:

___Measles	___Polio	___Mumps
___Mononucleosis	___Chicken Pox	___Meningitis
___Whooping Cough	___Hepatitis	___Scarlet Fever
___Encephalitis	___Pneumonia	___Fainting Spells
___Asthma	___Frequent cold sore/sore throats	
___Frequent headaches	___Allergies	___Seizures
___Tonsillitis	___Hearing problems	___Vision problems
___Frequent ear infections	___Diabetes	___High fevers
___Venereal disease	___Rapid weight gain/loss	___Head injuries
___Broken bones	___Ulcers	___Hay fever
___Pregnancy	___Other:	

2. Have you ever been hospitalized? ___yes ___no
   If yes, list the approximate date, age, reason, and length of time in hospital.

3. Please note below all medications you have been on in the past month.
   Place an asterisk beside those medications you are currently on. (*)

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4. Please indicate approximately how long it has been since you have had a medical check-up.

5. Please discuss how you take care of yourself spiritually.

Family Information

Please complete the following for those currently living in the household.

Name	Sex	Age	Level of Education	Occupation	Relationship

How do you get along with members of the current household?

Please discuss any traumas or significant losses (e.g. sexual or physical abuse, deaths, moves, loss of parent/sibing) have you experienced in the past? Please indicate the approximate dates they occurred, as well.

What would you like to accomplish in counseling?

1.

2.

3.

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