Adult Psychotherapy Intake Form

Full Name _____ Today's Date_____

Male_____ Female_____ Date of Birth_____ Age_____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Is it OK to contact you at home? _____OK to leave a message? _____

Mobile Telephone _____ Is it OK to contact this number? _____OK to leave a message? _____

How did you learn about the psychotherapy services provided at this office: _____
_____

REASON FOR SEEKING TREATMENT:
Please briefly describe the problems you are experiencing.
_____
_____
_____
_____

What has happened to cause you to seek help now?
_____
_____

What do you hope to be able to do or achieve as a result of treatment?
_____
_____

How do you handle stressors and/or cope with the problems you have described:
_____
_____
_____

Do you currently have thoughts of harming yourself? □ yes □ no
Have you in the past? □ yes □ no If Yes, how long ago? _____

Do you currently have thoughts of wishing you were dead? □ yes □ no

Do you currently have urges to hurt, harm, or kill someone else? □ yes □ no If yes, whom? _____

Have you **ever** seriously considered suicide or felt like harming someone else? □ yes □ no
If yes, please explain: _____

Name of Current Psychiatrist (and phone #): _____

Have you ever had previous therapy/counseling of any kind? □ yes □ no If yes, when, with whom, and for how long?
_____
_____

Have you ever been hospitalized for emotional problems? □ yes □ no Or for substance abuse problems? □ yes □ no
If yes to either of the above, please note when, where, and for how long were you hospitalized? _____
_____
_____

HEALTH/MEDICAL INFORMATION:

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____
_____
_____
_____

Do any of these problems affect your everyday life? □ yes □ no If yes, how so? _____
_____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): _____
_____
_____
_____

Have you ever blacked out / lost consciousness and/or experienced any type of serious head injury or trauma? □ yes □ no
If so, please indicate when and what happened.
_____
_____
_____

List all medications that you currently use:

Medication(s) _____
_____
_____
_____

Dosage (amount and times per day) _____

Reason(s)_____

Name of Medication Prescriber: _____

Name of Primary Care Physician (PCP): _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship _____

Address _____
(Street, Apt #) (City) (State) (Zip Code)

Telephone # Daytime _____ Evening _____

Cell Phone_____

6.0 Signature

Date _____