

# ADULT CLIENT INTAKE FORM

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Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy.

Name: \_\_\_\_\_  
(Last) (Given) (Preferred) (Middle Initial)

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female Transgender

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_

Current address: \_\_\_\_\_  
(city) (state) (zip)

Home phone: \_\_\_\_\_ May we leave a message? Yes No

Cell/other: \_\_\_\_\_ May we leave a message? Yes No

Work phone: \_\_\_\_\_ May we leave a message? Yes No

Email: \_\_\_\_\_ May we email you?\* Yes No

\*NOTE: Emails may not be confidential

Who may we contact in case of an emergency: \_\_\_\_\_ Telephone number \_\_\_\_\_

Referred by: Insurance company Internet search Word of mouth Advertisement Other: \_\_\_\_\_

Primary insurance co & identification number: \_\_\_\_\_

Insurance subscriber name and date of birth: \_\_\_\_\_

Secondary insurance identification number: \_\_\_\_\_

Insurance subscriber name and date of birth: \_\_\_\_\_

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change: \_\_\_\_\_

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list: \_\_\_\_\_

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list: \_\_\_\_\_

Have you been psychiatrically hospitalized in the past? Yes No

If yes, please list dates and locations: \_\_\_\_\_

## General Health Information

Please provide the name, address and telephone number for your primary care physician: \_\_\_\_\_

How is your physical health at the present time? Poor    Unsatisfactory    Satisfactory    Good    Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): \_\_\_\_\_

Are you on any medication for physical/medical issues? Yes                      No

If yes, please list: \_\_\_\_\_

Are you having any problems with your sleep habits?                      Yes                      No

If yes, circle those that apply:

Sleep too much      Sleep too little      Poor quality      Disturbing dreams      Other: \_\_\_\_\_

Are there any changes or difficulties with your eating habits?    Yes                      No

If yes, circle those that apply:

Eating less              Eating more              Bingeing              Restricting              Other: \_\_\_\_\_

Have you experienced a weight change in the last two months?    Yes                      No

Do you exercise regularly?                      Yes                      No

If yes, how many days per week do you exercise? \_\_\_\_\_ How many minutes/hours per session: \_\_\_\_\_

Do you consume alcohol regularly?                      Yes                      No

In one month, how many times do you have four or more drinks in a 24-hour period? \_\_\_\_\_

How often do you engage in recreational drug use?    Daily              Weekly              Monthly              Rarely              Never

What kinds of recreational drugs do you use: \_\_\_\_\_

Are you currently in a romantic relationship?                      Yes                      No

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? \_\_\_\_\_

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

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## Quick Check

Check the issues below that apply to you.

Depressed mood	Panic Attacks	Memory Lapse	Relationship Problems
Mood Swings	Phobias	Trouble planning	Hallucinations
Rapid Speech	Repetitive Behaviors	Sleep Disturbance	Eating difficulties
Suicidal Thoughts	Anxiety	Time loss	Body Complaints
Homicidal thoughts	Excessive Worry	Alcohol/Drug abuse	Traumatic Event

Have you felt depressed recently? Yes No

If yes, for how long? \_\_\_\_\_

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long ago? \_\_\_\_\_

How often did you have these thoughts? Frequently Sometimes Rarely

## Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Suicide	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Sexual Abuse	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____



By signing below, I am acknowledging that I have chosen to receive mental health services in the form of evaluation and psychotherapy from Dr. Robin Lowey & Associates Psychological Services. My decision is voluntary and I understand that I may terminate these services at any time. I also understand that during the course of treatment I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after completion of treatment.

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Signature

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Date