ParentingONCALL
Compassion. Results. Harmony.

Adult Initial Intake Form

A. Identifications

Name: _____ Birthdate: _____
Age: _____ Today's date: _____
Primary phone #: _____
Address: _____
Highest school grade completed?_____Occupation: _____
Email address:_____

Marital Status: _____

Religious denomination/affiliation (specify, if applicable): _____
Involvement: ❑ None ❑ Some/irregular ❑ Active

Ethnicity/national origin: _____
Other important identifiers: _____

B. Referral: How did you find out about my practice?_____

C. Medical care: From whom or where do you receive medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
May I contact your medical doctor so that he or she can be fully informed and we can coordinate treatment?
❑ Yes ❑ No

Health Insurance Information (I will need to make a copy of your card(s))

Name of Primary insurance company:_____
Primary Subscriber's Name, Date of Birth, and Address:_____
Member ID number:_____ Group number (if applicable):_____

Name of Secondary insurance company:_____
Primary Subscriber's Name, Date of Birth, and Address:_____
Member ID number:_____ Group number (if applicable):_____

D. Emergency information
If some kind of emergency arises and I cannot reach you directly, whom should I call?
Name: _____ Phone: _____ Relationship: _____
Address: _____

E. Chief concern
Please describe the main difficulty that has brought you to see me. How long has it persisted?
_____
_____

_____
_____

F. Prior Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____

2. What medication(s) are you currently taking? If applicable, please indicate the medication, the dosage, and the prescribing physician:_____

What medication(s) have you taken in the past?:_____
3. Have you ever received psychological testing? If so, whom may I contact for a copy of the report?_____
_____

G. Health

List all illnesses, hospitalizations, medications, allergies, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(list more on the back of this page if necessary)

Is there a family history of any medical or mental health problems? Please describe:_____
_____
_____

Have you ever been exposed to traumatic events (the loss of a loved one, a natural disaster, etc.) or been subject to abuse or neglect (physical, verbal, sexual, or emotional)? Please describe:_____
_____

H. Unique attributes

What are your hobbies? What do you do for fun? _____
_____
_____
What do you see as being your strengths and weaknesses?_____

_____
_____

I. Relationships
Please briefly characterize how you get along with:
Family:_____
_____
_____
Significant Other: _____
_____
_____
Friends: _____
_____
_____
Other important relationships: _____
_____

J**. Risk taking**
Do you have a history of behaviors such as lying, stealing, excessively using drugs or alcohol, fighting, etc.?
_____
_____

If so, have you had any serious consequences (problems at school or work, legal involvement, etc.)? Please describe:_____
_____

K. Other

Are there any stressful events occurring in your life right now that could be affecting you?_____
_____

Is there anything else I should know about that does not appear on this form and that might be important?
_____
_____
_____