Adult Intake Form

Name: _____ Age: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Occupation: _____ Employer: _____

Cell Phone: _____ Email: _____

I give Dr. Stone permission to leave messages via: ___text ____email ____voicemail

Education (Highest level of education attained): _____

Spouse's Name: _____ Occupation _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Date of last visit: _____

Please list any significant health problems: _____

_____

Please list any medications you are taking and who prescribed them:

_____

_____

Have you had counseling previously? Yes _____ No _____

If yes, when and with whom? _____

_____

What is your religious affiliation? _____

What are the reasons you are coming into counseling at this time?

What changes do you hope to see as a result of counseling?

Circle all the behaviors and symptoms you consider problematic in your life right now:

Worrying	Sadness	Religious/spiritual concerns
Panic attacks	Hopelessness	Difficulty making decisions
Social discomfort	Crying easily	Flashbacks
Racing heart	Fatigue	Recurring, disturbing memories
Poor appetite	Feeling inferior	Bad dreams
Headaches	Poor concentration	Loss of interest in things
Sleep disturbance	Poor memory	Thoughts of harm to others
Obsessive thoughts	Health concerns	Thoughts of death
Feeling fearful	Problems at work	Self-harm behaviors
Outburst of temper	Irritability/anger	Alcohol/drug use
Marital concerns	Family/friend relationships	Parenting concerns

Have you ever experienced any sort of trauma or loss in your life? If so, describe. _____

_____

_____

In general, how would you describe your years growing up in your family home? _____

_____

_____

Is there a history of mental health problems in your family? Which family members? _____

_____

Are they currently taking any medications to treat these problems? _____

_____

How did you get referred to Dr. Stone? _____

If appropriate, may Dr. Stone communicate with your referral source to let them know you have followed up on their recommendation for services? If so, please sign below.

_____ _____

Name Date

Do you have any questions today for Dr. Stone? _____

_____