



# ADULT INTAKE FORM

## Family Psychology Associates Strengthening relationships...improving lives.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Education: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status:      Married \_\_\_\_\_      Separated \_\_\_\_\_  
                                 Divorced \_\_\_\_\_      Widowed \_\_\_\_\_  
                                 Single \_\_\_\_\_      Other \_\_\_\_\_

Date of Most Recent Marriage: \_\_\_\_\_ Date Divorced/Widowed: \_\_\_\_\_

Other Marriages: \_\_\_\_\_

### Household Members:

Name	Age	Grade/Occupation	Relationship
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Are you currently under a doctor's care? Yes \_\_\_\_\_ No \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Other doctors involved in your care: \_\_\_\_\_

Current Health Problems or Symptoms: \_\_\_\_\_

Do you have any allergies or adverse reactions to particular drugs or substances?

\_\_\_\_\_  
\_\_\_\_\_



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Medications you are currently using and why:

Medication	Dosage	Doctor Prescribing	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Treatments for Medical Problems, Accidents or Injuries: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Would you like your physician to be contacted by us or receive a copy of your treatment plan? Yes \_\_\_\_ No \_\_\_\_  
 If so, please supply the physician's name, phone number, and/or fax number: \_\_\_\_\_  
 \_\_\_\_\_

Current alcohol or drug use? \_\_\_\_\_  
 Do you have any past history of problems related to alcohol or drug use? If so, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you been seen previously by a Psychologist, Psychiatrist or other Mental Health Professional? Yes \_\_\_ No \_\_\_  
 Name of Clinician: \_\_\_\_\_  
 Address and Phone # if known: \_\_\_\_\_  
 \_\_\_\_\_

When? \_\_\_\_\_  
 Reason for prior counseling? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been hospitalized for treatment of emotional or substance abuse problems? Yes \_\_\_\_ No \_\_\_\_  
 If so, when? \_\_\_\_\_

Do you have a past history of:  
 Sexual Abuse \_\_\_\_\_ Physical Abuse \_\_\_\_\_  
 Emotional Abuse \_\_\_\_\_ Other Trauma (specify) \_\_\_\_\_  
 \_\_\_\_\_



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Do you have any history of, or current involvement in court proceedings? (i.e. divorce litigation, arrests or convictions for other than minor offenses) \_\_\_\_\_

Are there any spiritual or cultural issues that might affect your treatment? \_\_\_\_\_

Why are you seeking counseling at this time? \_\_\_\_\_

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(This information will be held confidential and privileged)