Adult Intake Form

Date _____

Name _____
Street Address _____
City _____ Zip Code _____
Employer _____ How Long _____
Emergency Contact _____ Main Phone _____ Text Ok
Alt Phone _____ Email _____ Birthday _____
Education _____

What is happening in your life which led to this appointment?

_____
_____
_____
_____

Are you experiencing any symptoms of Depression or Anxiety?

Depression	Feeling Worthless	Sadness/Loss	Low Energy	Sleep Problems
Self-Harming	Appetite Problems	Low Self-Esteem	Suicidal Thoughts	Guilt
Worry	Rumination	Restless	Irritable	Zoning Out
Overactive Thoughts	Re-experiencing Trauma	Intrusive Thoughts	Hyper Vigilant	Avoiding people Places/situations
Obsessive Thoughts	Muscle Tension	Distracted	Fearful	Compulsive Behaviors
Suicidal Thoughts	Nightmares			

Are you experiencing any symptoms of Psychosis?

Racing Thoughts	Very Talkative	Easily Agitated	Low Energy	Restless
Grandiose Thoughts	Excessive Sexual Activity	Daily/Binge Drug Or Alcohol Use	Feeling Out of Control	Thoughts of Hurting someone
Seeing or Hearing Things	Feeling like things are not real	Eccentric Thoughts	Losing track Of time	

Have you recently experienced any recent significant stressors?

Loss of a Loved one or pet	Relationship Problems	Work Problems	Victim of A Crime	Car Accident
Legal Troubles	Financial Troubles	Housing Problems	Job Change Or Retirement	Move

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Past Counseling For What _____ Medications _____

How do you see therapy helping improve your circumstances, feelings and thoughts ?