Adult Intake Form

Client Information

Full Legal Name: ____
Preferred Name (if different): _______________________________
Date of Birth: __________________ Age: _______
Pronouns: ____

Street Address: ____
City: __________________________ State: _____ ZIP: _______

Phone Number: __________________________
☐ May we leave a voicemail? ☐ Yes ☐ No

Email Address: ____
☐ May we email you regarding scheduling/billing? ☐ Yes ☐ No

Emergency Contact Name: _______________________________
Relationship: ___________________ Phone: ___________________

Demographic & Background Information (Optional)

Gender Identity: ____
Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say

Race/Ethnicity: ____
Primary Language: ______________________________
☐ Interpreter needed

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment & Education

Employment Status: ☐ Employed FT ☐ Employed PT ☐ Self-Employed ☐ Student ☐ Unemployed ☐ Retired

Employer/School Name: ____
Occupation/Program: ____

Insurance Information (If Applicable)

Insurance Provider: ____
Policy Holder Name: ____
Policy Holder DOB: ___________________
Member ID #: __________________________

Medical & Mental Health History

Primary Care Provider (Name & Phone):
____

Current Medications (include dosage & prescribing provider):

____

Medical Conditions (past or present):

____

Previous Mental Health Treatment: ☐ No ☐ Yes (please explain)

____

History of Psychiatric Hospitalization: ☐ No ☐ Yes (dates/reason)
____

Reason for Seeking Services

Please describe what brings you to counseling at this time:

____
____
____
____
____
____
____

Goals for Counseling

____
____
____

Trauma & Life Experiences (Answer only what you are comfortable sharing)

Have you experienced any of the following? (Check all that apply)

☐ Emotional abuse
☐ Physical abuse
☐ Sexual abuse/assault
☐ Domestic violence
☐ Neglect
☐ Childhood trauma
☐ Medical trauma
☐ Loss/grief
☐ Other: ________________________________

Would you like trauma-informed care to be part of your treatment? ☐ Yes ☐

Suicide Risk & Safety Assessment

Have you experienced any of the following within the past 30 days? (Check all that apply)
☐ Thoughts of wanting to die
☐ Thoughts of harming yourself

☐ Previous suicide attempt(s)
☐ Current plan or intent
☐ Self-harm behaviors (past or present)
☐ None of the above
If yes, please describe (you may keep this brief):
Protective Factors (optional):
☐ Family/friends
☐ Faith/spiritual beliefs
☐ Children/pets
☐ Personal goals
☐ Other: ______________________________
If you are currently in danger or at immediate risk, please call 911 or go to the nearest emergency room.

Substance Use History

Please indicate any current or past use:
☐ Alcohol
☐ Marijuana
☐ Tobacco/Nicotine
☐ Prescription medication (non-prescribed use)
☐ Other substances: ______________________________
☐ No substance use concerns
Frequency (if applicable): ____________________________________

Family & Social History

Who currently lives in your household?

____

Do you have supportive relationships in your life? ☐ Yes ☐ No ☐ Somewhat

Significant family history of mental health or substance use concerns?
☐ No ☐ Yes (please describe):

____

Spiritual / Cultural Considerations (Optional)

Are spiritual, faith-based, or cultural values important to you in counseling?
☐ Yes ☐ No ☐ Unsure
If yes, please share anything you'd like your therapist to be aware of:

____

Strengths & Coping

What personal strengths or coping strategies have helped you in the past?

____

____

Client Acknowledgment & Consent

I understand that counseling is a collaborative process and that results cannot be guaranteed. I acknowledge that I have provided accurate information to the best of my ability.

Client Signature: ____________________________________
Date: ____________________