



ADULT INTAKE

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Briefly describe your reason for seeking help: _____

May I thank someone for referring you? _____

What is your religious affiliation? _____

Education/Degrees: _____

Occupation: _____ How Long: _____

Place of Employment: _____ How Long: _____

If not employed, how long has it been since you worked? _____

Marital Status: Single Married Divorced Separated Widowed
 Living Together

Current and Past Marriages or Significant Relationships

To Whom	Length of Relationship	Children from Relationship (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____

If married, separated or living together, briefly describe your relationship: _____

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/Drugs	How do you get along?

Extended Family: Parents, Siblings and others close to you

Name	Relationship	Age	Occupation	Challenges (alcohol, mental illness, etc)

What was it like to grow up in your family? _____

Medical Information

When were you last examined by a physician? _____ Name of Doctor: _____
 List any health problems for which you currently receive treatment and medications _____

Psychological Information

Have you ever sought help or been treated for psychological or emotional reasons? _____
 If so, when and where? _____
 What was the outcome? _____

Have you ever had any previous treatment for drug/alcohol use? _____

Is this an area of concern for you? _____

Circle any problem that pertains to you at the present:

- | | | | | |
|---------------|-----------------|--------------------|----------------|-------------------|
| Anger | Education | Sexual Issues | Work | Drug Use |
| Loneliness | Marriage | Fatigue | Ambition | Stomach Problems |
| Divorce | Finances | Appearance | Age | Suicidal Thoughts |
| Future | Friends | Concentration | Nightmares | Temper |
| Parenthood | Health Problems | Nervousness | Relaxation | Making Decisions |
| Stress | Self-esteem | Sexual Orientation | Physical Abuse | Anxiety |
| Sexual Abuse | Children | Career Choices | Weight | Shyness |
| Legal Matters | Self Control | Memory | Sleep | Under/Overeating |
| Alcohol Use | Unhappiness | Depression | Headaches | Fears |

Other: _____

Circle everything that you have experiences in the past three years:

- | | | |
|----------------------------------|--------------------|-------------------------------|
| Death of a spouse/partner | Marriage problems | Changes in Marital Status |
| Death of a family member | Family Problems | Loss of Job |
| Major illness or injury (self) | Financial Problems | Move to another city or state |
| Major illness or injury (family) | Legal Problems | |

Please list any additional information you would like for me to have: _____

What is the best way for me to contact you if necessary? _____
