



ADULT INTAKE FORM

Full Name: _____ SSN: _____
Date of Birth: _____ Gender: Male Female
Address: _____

Home Phone: _____ day/evening OK to leave msg? Yes No
Work Phone: _____ day/evening OK to leave msg? Yes No
Cell Phone: _____ day/evening OK to leave msg? Yes No

Referred by (Name/Agency): _____
Primary Care Physician: _____ Phone: _____

School/Employment (if applicable):

Current School/College: _____ Grade/year: _____
Highest Educational Level completed (circle): 8 9 10 11 12 13 14 15 16 17 18 19+
Occupation: _____
Employer: _____ For how long? _____

Marital Status:

Single Involved Cohabiting Engaged
 Married Separated Widowed Divorced

Please describe your ethnic background: _____

List names and ages of all individuals residing in your household:

Name: _____ Age: ____ Relationship to you: _____
Name: _____ Age: ____ Relationship to you: _____
Name: _____ Age: ____ Relationship to you: _____
Name: _____ Age: ____ Relationship to you: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Phone #: _____
Ins. Co. Address: _____
Subscriber's Name: _____ Subscriber Birthdate: _____
ID #: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Phone #: _____
Ins. Co. Address: _____
Subscriber's Name: _____ Subscriber Birthdate: _____
ID #: _____ Group/Plan #: _____

REASON FOR VISIT

Briefly describe your primary concerns and why you sought these services:

FAMILY SITUATION

Relationship Status of Parents:

Cohabiting Married Separated Divorced Widowed Remarried (circle Mother, Father, or Both)

Mother's Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Father's Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

FAMILY HISTORY

List any *immediate or extended family members* with a history of concerns in the areas listed below. Please indicate their relationship to the child and provide more detailed information, such as specific diagnosis. There is additional space on the final page if needed.

Chronic Physical Health Issues

Past: _____

Present: _____

Mental Health Concerns

Past: _____

Present: _____

Learning and/or Attention Concerns

Past: _____

Present: _____

Developmental Delay and/or Autism Spectrum Disorders

Past: _____

Present: _____

Drug/Alcohol Dependence or Abuse

Past: _____

Present: _____

Physical/Sexual Abuse and/or Neglect

Past: _____

Present: _____

Domestic Violence

Past: _____

Present: _____

MEDICAL HISTORY

How is your general health? Excellent Good Fair Poor

When was your last comprehensive medical evaluation? _____

List any serious illnesses for which you required hospitalization or surgical operation:

Illness: _____ Year: ____ Doctor/Hospital: _____

Illness: _____ Year: ____ Doctor/Hospital: _____

Illness: _____ Year: ____ Doctor/Hospital: _____

Are you currently taking any medications/supplements/vitamins? Yes No

Medication: _____ Dosage: _____ Date Started: _____ Prescriber: _____

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Medication: _____ Dosage: _____ Date Started: _____ Prescriber: _____

Supplement/Vitamin: _____ Dosage: _____ Date Started: _____

Supplement/Vitamin: _____ Dosage: _____ Date Started: _____

List previous or current counseling, substance abuse services, psychiatric services, hospitalizations for mental health reasons, or psychological, speech/language, or occupational therapy assessment or services.

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Service: _____ Year Started: _____ Currently receiving services? Yes No

Doctor/Therapist/Agency: _____

Please check whether you currently have or have ever had any of the following:

Attention/Educational Issues	Developmental/Medical Issues	Emotional/Behavioral Issues
<input type="checkbox"/> Inattention	<input type="checkbox"/> Speech delay/problems	<input type="checkbox"/> Verbal aggression/defiance
<input type="checkbox"/> Organizational difficulties	<input type="checkbox"/> Fine/Gross motor delay	<input type="checkbox"/> Difficulty managing anger
<input type="checkbox"/> Academic delays/concerns	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Physically aggressive
<input type="checkbox"/> Memory concerns	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Sexualized behavior
<input type="checkbox"/> Peer conflict/bullying	<input type="checkbox"/> Bedwetting/bowel problems	<input type="checkbox"/> Low self-esteem
	<input type="checkbox"/> Head injury/concussion	<input type="checkbox"/> Depressed mood/withdrawn
Stresses/Trauma	<input type="checkbox"/> Frequent stomachaches	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Family issues/conflict	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Witness to domestic violence	<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Ritualistic/Repetitive behaviors
<input type="checkbox"/> Multiple moves	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Irritability
<input type="checkbox"/> Deaths or losses	<input type="checkbox"/> Self-injurious behavior	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Chronic illness in family		<input type="checkbox"/> Disturbing thoughts
<input type="checkbox"/> History of sexual abuse		<input type="checkbox"/> Feelings of hopelessness
<input type="checkbox"/> History of physical abuse		<input type="checkbox"/> Extreme fears
<input type="checkbox"/> History of emotional abuse		<input type="checkbox"/> Running away
<input type="checkbox"/> History of neglect		<input type="checkbox"/> Suicidal thoughts/attempts
<input type="checkbox"/> Legal issues		<input type="checkbox"/> Drug/alcohol use

Thank you for providing this information.

Additional comments/personal or family history: