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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 ☐ Cohabitating ☐ 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:
☐Cohabitating ☐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: ______________

Medication:____________________ Dosage: _____ Date Started: ______ Prescriber: ______________

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	_ Head injury/concussion	_ Depressed mood/withdrawn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

Thank you for providing this information.

Additional comments/personal or family history: