485 S. Independence Blvd. Suite 104
Virginia Beach, VA 23452
Phone:(757) 409-7613
Fax:(757) 634-3926

ADULT INTAKE FORM

CLIENT INFORMATION

Today's Date: ___________ Referred By______________________

Client's Name:____

Date of Birth: ___________ Age: ___________

Client's Address: ____

City: ________________________ Sate: ______ Zip:______________

Phone (Home)_________________ (Work)______________________

Phone (Cell) ___________________(Cell 2) ____________________

E-mail: ____

Occupation: ____

Employer: ____

Marital Status: ☐ Married ☐Engaged ☐Widowed ☐Divorced

☐Separated ☐Live with Partner ☐Other __________________

Name of spouse: ____

Do you attend church? ☐Yes ☐No

Church Name: ____

EMERGENCY CONTACT

Name: ____

Phone Number ________________________

Relation: ______________________________

MENTAL HEALTH TREATMENT

Have you seen a therapist/counselor? ☐Yes ☐No

Therapist/Counselor Name:__________________________________

Have you seen a psychiatrist? ☐Yes ☐No

Psychiatrist Name: ____

Have you had a previous mental health diagnosis? ☐Yes ☐No

If Yes: ____

MEDICAL AND PERSONAL

Primary Care Physician: _______________________________________

Office Phone: ______________________ Fax: _____________________

Address: ____

City: _________________________ State: ______ Zip: ____________

Specialist: ____

Type of Physician: ____

Office Phone: ______________________ Fax: _____________________

Address: ____

City: _________________________ State: ______ Zip: ____________

FAMILY COMPOSITION

Who currently resides in the same house as the? Please include Family members as well.

	Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ADULT INTAKE FORM

CURRENT MEDICATION PRESCRIBED

Name of Medication	Dosage	Frequency	Treatment for

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- ☐ Depressed
- ☐ Restlessness
- ☐ Overeating
- ☐ Withholding food
- ☐ Confusion
- ☐ Nausea
- ☐ Hallucinations
- ☐ Upset bowels
- ☐ Heart Racing
- ☐ Lack of energy
- ☐ Racing thoughts
- ☐ Stomach aches
- ☐ Indecisiveness
- ☐ Dizziness
- ☐ Self-mutilation
- ☐ Poor memory
- ☐ Chest pains
- ☐ Violent behaviors
- ☐ Guilty conscience
- ☐ Seizures or convulsions
- ☐ Anxiety or nervousness
- ☐ Feelings of unreality
- ☐ Heart irregularities
- ☐ Feelings of sadness
- ☐ Addicted to pornography
- ☐ Feelings of worthlessness
- ☐ Suicidal thoughts
- ☐ Always “on guard”
- ☐ Excessive guilt or shame
- ☐ Unusual sexual behavior
- ☐ Feelings of loneliness
- ☐ Headaches
- ☐ Periods of “going blank”
- ☐ Sleeping to much
- ☐ Outbursts of anger
- ☐ Inability to sleep
- ☐ Shortness of breath
- ☐ Financial difficulties
- ☐ Difficulty making choices
- ☐ Uncontrolled crying spells
- ☐ Loss of consciousness
- ☐ Weight loss/gain
- ☐ Involuntary body trembling
- ☐ Loss or decrease of sex drive
- ☐ Tingling or numbness
- ☐ Excessive sweating
- ☐ Sensitivity to criticism
- ☐ Fear of “going insane”
- ☐ Fear of being alone
- ☐ Recurrent thoughts or worries
- ☐ Feeling compelled to do things
- ☐ Trouble getting along with others
- ☐ Avoiding people/social situations
- ☐ Neglected hygiene/appearance
- ☐ Weight loss by vomiting/laxatives
- ☐ Loss of interest in usual activities
- ☐ Difficulty thinking/distractions
- ☐ Preoccupation w/ bodily functions
- ☐ Difficulties at work or school
- ☐ Constant focus religious thoughts
- ☐ Moodiness, changeable moods
- ☐ Feeling as if reliving past trauma
- ☐ Excessive fear of persons, places
- ☐ Feelings of doom or death
- ☐ Recurring distressing dreams

ADULT INTAKE FORM

PRESENTING PROBLEM

What brings you here today?