Adult Intake

Please provide the information below. The information you provide is confidential.

Full Name_____
Nickname_____

Address_____
_____

Telephone_____

E-mail_____
Please note: e-mail correspondence is not confidential

Birth date_____

Marital Status: Never Married____
Divorced____Separated____Married____Widowed____Domestic Partnership____

Please list any children/age_____

Employment_____

If you are currently a student, name of
school_____

Referred to counseling by_____

Primary Care Physician_____
Primary Care Physician
Address_____
Phone_____

Are you taking any medications? _____

Name of medication and
dosage_____
_____

Do you smoke or have you in the past? _____

Do you use alcohol or drugs or have you in the past?
_____

Please describe any past counseling you have had_____
_____
_____
_____
___

Education History

Name of High School_____
Date of Graduation_____

Name of College or Technical School_____
Date of Graduation_____

Name of Graduate School_____
Date of Graduation_____

What brought you to counseling at this time?

_____
_____
_____
_____
_____
_____
_____