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ADULT INTAKE

Please take the time to fill this out as completely and accurately as possible. By filling out this questionnaire, more time can be spent with your provider discussing your case, your current concerns, and your treatment plan. Please be sure to bring this with you for your initial appointment.

Today's Date _____

Client's name: _____ Age _____ Date of Birth _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: (_____) _____ Cell (_____) _____ Work (_____) _____
Occupation: _____ Employer: _____ # of years of Education _____

Client's Marital status:

single married (years married _____) (# of times married _____)
 separated (how long _____) Divorced (how long _____)

Spouse's name: _____ Age _____ Date of Birth _____
Cell (_____) _____ Work (_____) _____ Number of times married _____
Occupation: _____ Employer: _____ Spouse's Education _____

Children Information:

_____ age _____ full half(maternal or paternal) step other _____
_____ age _____ full half(maternal or paternal) step other _____
_____ age _____ full half(maternal or paternal) step other _____
_____ age _____ full half(maternal or paternal) step other _____
_____ age _____ full half(maternal or paternal) step other _____
_____ age _____ full half(maternal or paternal) step other _____

Who else lives in the home (name and relationship to client)? _____

Has the patient seen a psychiatrist, psychologist, or counselor before? Yes No
If yes, when? _____ Where? _____ Whom? _____

Emergency Contact Person

Name _____ relationship _____
Phone number _____ cell work home
Address _____

Please note the reason(s) for this appointment: (circle any that apply)

Depression	Sexual concerns	Family problems	Parenting concerns
Anxiety	Eating disorder	Marital problems	Anger control
Panic Attacks	Traumatic stress	Relationship problems	Spiritual Issues
Mood swings	Voices/visions	Work problems	Grief
Suicidal thoughts	Alcohol/drug abuse	School problems	Negative thoughts
Poor memory	Compulsive behavior	Gambling	Financial problems
Poor concentration issues	Obsessions	Sleep problems	Self-esteem

Other: _____

Please give a brief explanation below:

CRISIS INFORMATION:

Any current suicidal thoughts, feelings, or actions? yes no

If yes, explain: _____

Any current thoughts of assault or homicide? yes no

If yes, explain: _____

Any past problems or imprisonment for violent behavior? yes no

If yes, explain: _____

Any current *fears of* significant loss or harm (illness, divorce, custody, job loss, etc.)? yes no

If yes, explain: _____

Have you ever been hospitalized for mental health problems? Yes _____ No _____

Hospital: _____ Date: _____

Doctor: _____ Length of stay: _____

List any prescription and over-the-counter medications you have taken are taking regularly for the past year.

Name of medication: _____ Dosage: _____ Length of use: _____

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Use the reverse of this page if you need more room.

Faith Information:

Please briefly describe your spiritual life and the role it plays into your family's life.

Do you attend church? [] No [] Yes, if so, where? _____

Please list any other factors, which may not have been discussed, that you feel may play an important part in your counseling experience.

Who referred you? _____

Name: _____ Relationship: _____

May I thank them for the referral? Yes No (Please Circle)

By signing below, I am agreeing that I understand the questions asked of me.

By signing below, I am agreeing that I have answered the above questions to the best of my knowledge.

I have to the best of my knowledge, provided accurate answers to the above questions.

Adult's signature: _____ Date: _____