



### Adult Intake

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_

Street City State Zip

Residence Phone: \_\_\_\_\_ OK to leave a message? Yes/ No  
Cell Phone: \_\_\_\_\_ OK to leave a message? Yes / No  
Work Phone: \_\_\_\_\_ OK to leave a message? Yes / No  
Social Security Number (optional): \_\_\_\_\_  
Marital Status (circle one): Single Married Separated Divorced Widowed  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_

Street City State Zip

Spouse's Name (if applicable): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Street City State Zip

Children (names and ages): \_\_\_\_\_

Emergency Contact:  
Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

Please list any illnesses and hospitalizations that you may have had: \_\_\_\_\_

Previous psychotherapy: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Briefly state your reasons for coming today: \_\_\_\_\_

Referred by: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Insurance ID: \_\_\_\_\_ Group Number: \_\_\_\_\_