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*MindfulnessAndTherapyCenter.com*

**ADULT INTAKE**

**IDENTIFYING INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City/State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best Method of Communication: \_\_\_\_\_

**PERSONAL INFORMATION**

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

SINGLE      MARRIED      SEPARATED      WIDOWED

Significant Other's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long: \_\_\_\_\_

Referred by: \_\_\_\_\_

**CURRENT CONCERNS**

Why are you seeking therapy right now?

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How long have these problems occurred?

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Problems perceived to be (Please circle):

Very serious

Somewhat Serious

Not Very Serious

What happened that makes you seek help at this time?

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What changes would you like to see in your life?

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What changes would you like to see in the relationships around you?

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Where are you getting stuck preventing change to occur?

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What habits and patterns would you like to change?

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What are your major stressors at the present time, if any?

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**CURRENT FAMILY SITUATION:**

Who do you currently reside with?

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Have there been any recent changes in your family or extended family?

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Marital history of the biological parents:

Married

Separated

Deceased

Divorced

Never Married

Name of brother / sister	Age	How related? Full / Half / Step / Other	Relationship? Good / Fair / Discord

**HEALTH OF FAMILY MEMBERS:**

List all the family who have had a history of depression, ADHD, anxiety, mood disorder, drug/alcohol abuse, behavioral problems, legal problems, or other psychological problems:

Name:	Relation:	Mental Health:	Drugs / Alcohol:	Legal:	Other:

\*Please list addition family members on the back of this page

**HEALTH INFORMATION:**

Note all health problems you have experienced currently or in the past:

Age	Age	Age
High Fever	Dental Problems	Pneumonia
Weight Problems	Flu	Allergies
Cancer	Meningitis	Convulsions
Unconsciousness	Concussions	Head Injury
Fainting	Dizziness	Tonsils Out
Vision Problems	Hearing Problems	Earaches
Skin Problems	Asthma	Headaches
Stomach Problems	Accident Prone	Anemia
High Blood Pressure	Low Blood Pressure	Sinus Problems
Heart Problems	Hyperactivity	STD
Infectious Disease	Other Illnesses	

If yes to any of the above, please explain:

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Have you ever been admitted to a hospital?      Yes      No

If yes, please explain:

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Have you ever seen a therapist/psychiatrist before? Please explain:

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Are you currently on any medication?

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If yes, please explain:

Medication:	Reason for Medication:	Dose:	How long:

\*Please list additional information on the back of this page

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

**PSYCHOSOCIAL HISTORY:**

Describe the nature of your relationships with friends/peers/co-workers:

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Describe your hobbies or ways that you like to spend your free time:

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Describe your strengths:

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Describe your level of satisfaction with where you are in life right now:

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Describe how you typically respond in times of stress or conflict:

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Who are the people in your life that are your support systems?

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Describe any additional information that would be beneficial for me to know in us working together:

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Client Signature

Date

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Therapist Signature

Date

\*All content is confidential with the Bay Area Mindfulness and Therapy Center