ChristyReeder, Ph.D.
licensed psychologist

Adult Intake Form

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: ◯ M ◯ F

Local Address: _____

City: _____ State: _____ Zip Code: _____

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone Number: _____ Ok to leave a message? ◯ Yes ◯ No

Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Educational Background

Highest Level of Education Completed: _____

Are you currently attending school? ◯ Yes ◯ No If yes, where?: _____

What was/is your major/educational focus in school? _____

Employment History

Please provide a brief history of your employment.

Place of Employment	Job Title / Responsibilities	Dates of Employment

Military Service

History of military service? ◯ Yes ◯ No

If yes, provide details: _____

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Relationship / Marital History

Relationship status: _____

Name of Significant Other	Dates Involved	Married or Cohabitated	Number of Children

Have you ever been the victim of physical, verbal, or emotional abuse in a romantic relationship? ◯ Yes ◯ No

Dependents / Children

Please list dependents and children.

Name	Age	Location / Residence

Living Arrangements

Who resides in your home?

Name	Age	Relationship	Occupation

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Social and Family History

Where were you born? _____ Raised? _____

Who raised you? _____

Were your parents together throughout your childhood? _____

How many siblings do you have? _____

Describe your relationship with:

Siblings: _____

Mother: _____

Father: _____

Family history of mental illness? ◯ Yes ◯ No

If yes, please describe: _____

Current sources of social support (Who do you confide in when necessary?):

_____

Religious affiliation (if any): _____

Are you an adopted person? ◯ Yes ◯ No If yes, have you met your birth family? ◯ Yes ◯ No

Are you a birth parent to a child you did not raise? ◯ Yes ◯ No

Mental Health Treatment History

Have you participated in therapy before? ◯ Yes ◯ No

Dates	Name of Therapist	Reason	Rate How Helpful (0 = not helpful 10 = most)

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Have you ever had medication prescribed for mental health reasons? ◯ Yes ◯ No

Please list (include current medications, if applicable):

Medication	Dose	Dates	Prescribing MD

Have you even been hospitalized for mental health reasons? ◯ Yes ◯ No

If yes, please describe (when, where, how long etc.):

Have you ever attempted suicide? ◯ Yes ◯ No

Physical Health History

Do you have any physical health problems/history of major illness or injury? ◯ Yes ◯ No

If yes, please describe:

Are you taking any medications? _____

Do you smoke? ◯ Yes ◯ No How much? _____

Do you drink alcohol? ◯ Yes ◯ No How much? _____

Do you use recreational drugs? ◯ Yes ◯ No Please list? _____

How often? _____ Last use: _____

Do you exercise? ◯ Yes ◯ No How often? _____

Legal History

Have you ever been the victim of a crime? ◯ Yes ◯ No

If yes, please describe:

Have you ever been arrested? ◯ Yes ◯ No

If yes, please describe:

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Are you currently involved in any litigation? ◯ Yes ◯ No

If yes, please describe:

_____

Reasons for Seeking Counseling

Briefly describe your primary reasons for seeking counseling at this time:

What are your goals for our time?

1. _____

2. _____

3. _____

Do you have any questions or concerns regarding counseling?

TO PRESERVE YOUR CONFIDENTIALITY,

PLEASE DO NOT SUBMIT COMPLETED INTAKE FORM THROUGH EMAIL.