Ebenezer Counseling Services

Adult Intake Form

Date________________

Name____

Address____

City___________________________________State_____________Zip__________

Home Phone______________________________Cell #__________________________

May we contact you at work?__________ If yes, work #_________________________

Social Security Number_____________________Date of Birth___________________

Age_______________Sex___________________Marital Status_________________

Presently Living with: Parents___Spouse___Roommate___Alone___Other________

Spouse's Name, if married____________________Years Married________________

If divorced, how long?______________Length of Previous Marriage(s)____________

Occupation__________________Employed by _______________Hours per week____

If a student, what school/university?______________________Full or Part-time_____

Who will be responsible for payment of bill?___________________________________

Relationship to patient?_________________Address if different__________________

Will you be using insurance?_______Primary Insurance Co.______________________

ID#______________________Group #____________Relationship________________

Policyholder Name______________________DOB________SSN________________

Education: Elementary School____High School____College____Other___________

Denomination or Church____

Active________ Inactive_______

- Please continue on back-

CONFIDENTIAL

Describe any physical problems you have that require medication or physical care:

____

Medication currently using: ____

Are you currently receiving medical treatment? Yes ________ No ________

Physician or health care provider ____

Previous Therapy / Hospitalization Yes ________ No ________

Where / with whom ____
Name Address Dates

<u>Problem Areas:</u> In the following list, place a check mark next to each item which identifies an area of concern to you. Place **two checks** by those items which are most important. *You may add written comments in the additional space below.*

1. _____ Anger / temper
2. _____ Depression
3. _____ Fearfulness / nightmares
4. _____ Unhappy most of the time / sadness
5. _____ Worry (constant)
6. _____ Family problems (siblings / parents)
7. _____ Family transitions (divorce, remarriage, birth)
8. _____ Responsibilities / chores
9. _____ Physical problems
10. _____ Religious / spiritual concerns
11. _____ Thoughts of suicide / hurting others
12. _____ Trouble making decisions
13. _____ Use of alcohol
14. _____ Use of drugs / cigarettes
15. _____ School concerns (grades, peer interaction)
16. _____ Problems with social relationships (friends)
17. _____ Sexual concerns
18. _____ Victim of uninvited sexual advances
19. _____ Other (specify) _______________

Additional comments regarding checked areas:

Is there any history of adoption in your family?

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In your own words, briefly describe the main problem which prompted you to seek therapy at this time.

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Is there anything else which you believe might be important for your therapist to know at this time?

____

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