Adult Intake Form

Barbara Massey LMFT Counseling

Welcome to counseling with Barbara Massey LMFT. The information asked for below is to help me understand you and your concerns. Please fill out this form as completely as you can. All information will be held in strict confidence.

Date of first appointment: _____

How did you hear about us? (Check one)
❑ Clergy persons ❑ Social Service Agency Family
❑ Friend ❑ Employer Internet site _____
❑ School ❑ Former Client Physician or other medical
Please include specific name if appropriate. _____

Name: _____
(Last) (First) (Middle)

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Work: _____

Phone Messages? Y/N
Email? Y/N _____ _____

Emergency Contact: _____
(Name) (Relationship) (Phone number)

Employer/School: _____ Occupation: _____

Education/Training: (Highest Level Obtained) _____

Military Service ❑ Yes ❑ No Dates: _____ Did you serve in combat? ❑ Yes ❑ No

Birth Date: _____ Age: _____ Height: _____ Weight: _____

Social Security Number _____

Sexual/Gender: ❑ _____ ❑ _____ _____ _____

Relationship Status: (Check one)
❑ Married ❑ Never Married ❑ Widowed ❑ Single
❑ Divorced ❑ Separated ❑ Lived/living together as partners

If married, date of present marriage _____ Children living at home p/t or f/t ? ❑ Yes ❑ No

Names and ages of children: _____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

Spouse/Partner Name: _____ Age: _____

Previous serious relationships/marriages: (date, how ended)
_____

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Name: _____ _____

Have you had previous therapy? _____

❑ Yes ❑ No Spiritual or Pastoral Counseling? ❑ Yes ❑ No

When _____ What issues _____

Are you presently seeing another therapist? ❑ Yes ❑ No

Your Physician's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

When was your last medical exam? _____

Are you currently on medication? ❑ Yes ❑ No

If so, what medication? _____

Prescribed by: _____

Major surgeries or illnesses in past five years? ❑ Yes ❑ No

For what condition(s): _____

Other health related conditions: _____

What do you believe your <u>physical</u> condition is at the present time? (Check one) Exercise? ❑ Poor ❑ Fair ❑ Average ❑ Good ❑ Excellent

What do you believe your <u>emotional</u> condition is at the present time? (Check one) ❑ Poor ❑ Fair ❑ Average ❑ Good ❑ Excellent

Which of the following describe or relate to the concerns which bring you here:

- ❑ Aging issues
- ❑ Anger
- ❑ Anxiety
- ❑ Frequent crying
- ❑ Eating/Food
- ❑ Alcohol/Drugs
- ❑ Loneliness
- ❑ Self doubt
- ❑ Guilt
- ❑ Sexual concerns
- ❑ Fear
- ❑ Grief
- ❑ Suicidal feelings *
- ❑ Religious doubts
- ❑ Legal Issues
- ❑ Finances
- ❑ Vocation/Career issues
- ❑ Physical health
- ❑ Self esteem
- ❑ Poor appetite
- ❑ Sleep disturbance
- ❑ Hopelessness *
- ❑ Weight Loss
- ❑ Mid-life issues

Relationship with:
- ❑ Partner
- ❑ Parents
- ❑ Children
- ❑ Others

Loss of:
- ❑ Self respect
- ❑ Faith
- ❑ Meaning
- ❑ Love

Abuse Issues:
- ❑ Physical
- ❑ Sexual
- ❑ Emotional

State in your own words the concerns that bring you to therapy:

_____

_____

What do you hope to achieve in therapy (your goals/expectations)?

_____

_____