INTOWN
COUNSELING & WELLNESS

Adult Intake Form

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

Birth Date: _____/_____/_____ Age:_____ Gender: Male / Female

Marital Status:_____

Address:_____

_____
(City) (State) (Zip)

Home Phone:_____ May we leave a message? Y/N

Cell/Other: _____ May we leave a **message** or **text** you? Y/N

Email: _____ May we e-mail you? Y/N

How were you referred to our office? _____

Emergency Contact Person: _____

Contact #: _____ Relationship: _____

Your Highest Education Attainment: _____

Current occupation and place of Employment/School_____

_____

1075 Zonolite Rd. | Suite 1A
Atlanta, GA 30306
O (404) 478-9890
F (404) 963-0975

Do you enjoy your current work? Is there anything particularly stressful about your current job?

Please list any children and ages:_____

Religious/Spiritual Beliefs:_____

Please describe any prior treatment including psychotherapy and use of medications.

Please tell us about the prescription medications your presently taking.

Do you have any significant medical conditions? Please explain.

Do you drink alcohol or use recreational substances? Y/N
If so, please describe the frequency of your use.

Please describe briefly why you are seeking therapy/psychological services at this time?
How long have these problems persisted?

Briefly tell us about your goals for therapy.

Please describe your current sleeping habits.

Please list any known family mental health concerns, including suicide and substance use.

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