Diana Lincoln-Haye, LPC, NCC, RRT

ADULT INTAKE FORM

Name:		**Date:**
SS #	**Age:**	**DOB:**
May I leave a text. or message on your phone?		**YES /NO**
Telephone numbers:	**Cell:**	**Wk:**
Address:_____		
Preferred way to be contacted (circle one):	**Cell** **Wk.Phone** **Email**	
May I contact you by E-mail? YES/NO	**Email:**	

Please include spouse/partner information if seeking couples/family therapy:

Name:			
SS #	**Age:**	**DOB:**	
Telephone numbers:	Cell:	**Work:**	
Address is different			
Preferred way to be contacted (circle one):	**Home**	**Work**	**Cell**
May I contact you by E-mail? YES/NO	**Email:**		

In case of an emergency, who may I contact on your behalf?

Name:	**Relationship:**
Phone Number:	**Address:**

If you have previously been married, please fill out the following section:

	Date began:	**Date ended:**	Children
1st Marriage			YES/NO
2nd Marriage			YES/NO
3rd Marriage			YES/NO

Name:

Relationship Status: (Circle all that apply)

Single	Married	Divorced	Separated
Widowed	Remarried	Long-term Relationship	Cohabitating

Current partner's name:	**Partner's Occupation:**	**Length of Relationship:**
How satisfied are you with your current relationship (on a scale from 1-10)? (very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)		
What is your occupation?	**Employer:**	
Do you enjoy your occupation: YES/NO	**Average hours worked per/week:**	

Highest level of education:	Highschool	Some college	College degree	Graduate School	Other
If you received a college/graduate degree, what was your degree in?					
If you are currently a student, what are you studying?					
How would you describe your spiritual or religious beliefs?					

Have you ever received or given abuse: YES/NO	**If yes please circle type:** Physical Emotional Sexual Neglect Other

Do you have a primary care physician? YES/NO	**Physicians name:**
Are you under the care of a psychiatrist? YES/NO	**Psychiatrists name:**

Are you under the care of a specialist? YES/NO					
If yes, please circle type of specialist:					
Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility	Nephrologist
Neurologist	Nutritionist	Occupational Therapist	Oncologist/ Hematologist	Orthopedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Name:

Please list any chronic illness, disabilities, or medical conditions that you have been diagnosed with:

Illness/Disability	Dates

List all medications you are currently taking:

Medication	**Dosage**	**Treating**
Are you taking the medications according to your doctor's recommendation? YES/NO If No, briefly explain:		

Average number of hours you sleep at night?	**How long does it take for you to fall asleep?** ____ min. ____ hrs.
Do you wake up in the night? YES/NO	**If yes, how often**? _____ times per night.
How would you rate your overall sleep at the present time? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	
Do you exercise on a regular basis? YES/NO **If yes how often?** ____ times per week.	
Have you ever attempted/seriously contemplated suicide? XDR.MN	
If yes, describe briefly and indicate dates:	