Building Foundations Counseling Center, Inc.
A Professional Family Counseling Corporation

Adult Intake Form

PATIENT INFORMATION

Patient Name:	Patient's Date of Birth:	Current Age:	Gender:	Pronoun Preferred:

Address:	City:	State:	Zip:	Today's Date:

Home Phone:	Cell Phone:	Work Phone:

May we identify this clinic when leaving a message at either or both of these numbers? ☐ YES ☐ NO

Ethnicity:	Occupation/Job Title:	Highest Educational Level Achieved:

Social Security Number:	Email:

REFERRAL INFORMATION

Reason for Referral: ☐ Individual ☐ Couples ☐ Family ☐ Group Therapy ☐ Other: _____

Referred By:	Phone:	Address:

INSURANCE INFORMATION

How do you intend to pay for services? ☐ Private Pay ☐ Insurance ☐ Victim Witness ☐ EAP ☐ Other:_____

Insurance Name:	Insurance Phone Numbers:

Insurance Address:	Subscriber's Name:

Subscriber's Social Security Number:	Subscriber's Date of Birth:	Relationship to Patient:

Member ID#:	Group ID#:

Name and Address of Employer:	Employer's Phone Number:

Is there secondary Insurance? ☐ YES ☐ NO	Secondary Insurance Name:

Insurance Address:	Subscriber's Name:

Subscriber's Date of Birth:	Member ID#:	Group ID#:

Victim Witness Claim #	Victim Witness Date of Incident:	EAP Authorization #:	EAP # Sessions

EMERGENCY CONTACT

Name:	Phone:	Relationship to You:

MEDICAL INFORMATION

Primary Physician Name:	Phone:
Medications Currently Taking:	
Medical Conditions:	
May we have your permission to contact your primary care physician to coordinate your treatment? ☐ YES ☐ NO	
Please describe your overall health today:	Have you ever been in a 12-Step program? ☐ YES ☐ NO If YES, please explain:

Do you use tobacco? ☐ YES ☐ NO	If YES, how often?	If YES for how long?
Do you drink alcohol? ☐ YES ☐ NO	If YES, how much alcohol do you consume in a week?	
Do you drink caffeine? ☐ YES ☐ NO	If YES, how much caffeine do you consume in a day?	

Do you currently use illegal drugs or misuse medications? ☐ YES ☐ NO	If YES, describe your use:
Have you ever used illegal drugs or misused medications? ☐ YES ☐ NO	If YES, please explain:

MENTAL HEALTH TREATMENT

	YES	NO	Name of Clinic or Person	List of Diagnoses, Medication, Type of Counseling or Service	Comments
Counseling Services:					
Psychiatric Treatment:					
Drug/Alcohol Treatment:					
Hospitalizations:					

Are you currently having any suicidal thoughts? ☐ YES ☐ NO	If YES, please explain:
Have you ever attempted to harm yourself currently or in the past? ☐ YES ☐ NO	If YES, please explain:
Are you currently having any homicidal thoughts? ☐ YES ☐ NO	If YES, please explain:
May we contact your current/recent treating psychiatrist listed above to coordinate your treatment? ☐ YES ☐ NO ☐ N/A	
May we contact your previous treating therapist or counselor above for continuity of care? ☐ YES ☐ NO ☐ N/A	

FAMILY MEMBERS/SIGNIFICANT OTHERS LIVING IN HOME OR IN YOUR LIFE

Name:	Age:	Relationship:
Name:	Age:	Relationship

FAMILY MEMBERS/SIGNIFICANT OTHERS LIVING IN HOME OR IN YOUR LIFE - Continued

Name:	Age:	Relationship:
Name:	Age:	Relationship
Name:	Age:	Relationship
Name:	Age:	Relationship

CURRENT CONCERNS AND SYMPTOMS

Please describe the problems for which you are seeking help at this time:

How long have you been concerned about these problems?

Do you notice any times that these symptoms/behaviors increase or decrease?

Please check if there have been any recent changes in the following:

☐ Sleeping Patterns	☐ Alcohol Consumption	☐ Behavior	☐ Physical Activity Level
☐ Eating Patterns	☐ Energy Level	☐ Weight	☐ Nervous/Tension
☐ Sex Drive	☐ Other: _____		

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

☐ Aggression	☐ Disorientation	☐ Heart Palpitations	☐ Procrastinating
☐ Alcohol Use	☐ Distractibility	☐ Hopelessness	☐ Recurring Thoughts
☐ Anger	☐ Dizziness	☐ Impulsivity	☐ Relationship Problems
☐ Anxiety	☐ Drug Dependence	☐ Irritability	☐ Repetitive Behaviors
☐ Anxiety/Panic Attacks	☐ Eating Disorder	☐ Judgment Errors	☐ Sadness/Frequent Crying
☐ Avoiding People	☐ Elevated Mood	☐ Loneliness	☐ Sick Often
☐ Chest Pain	☐ Fatigue	☐ Memory Impairments	☐ Sleeping Problems
☐ Cyber Addiction	☐ Fearful	☐ Mood Shifts	☐ Thoughts Disorganized
☐ Depression	☐ Gambling	☐ Nightmares/Night Terrors	☐ Withdrawing
☐ Difficulty Working	☐ Hallucinations	☐ Phobias/fears	☐ Worrying
		☐ Pornography	☐ Other:_____

Are there any factors/events in your life that are contributing to your symptoms?

☐ Problem with Children	☐ Remarriage/Blended Family Issues	☐ Financial Stress
☐ Problem with Parents	☐ Work Related Stress	☐ Legal Problems
☐ Marital Problems	☐ Recent Loss of a Loved One	☐ Trauma or Abuse
☐ Recent Divorce	☐ Problems with Friends/Co-Workers	☐ Other: _____

Are there any cultural values or spiritual beliefs that you feel would help therapist to understand you better?

GOALS FOR THERAPY

What are your goals/wishes/expectations of therapy?

Is there any other information that would assist the therapist in understanding your current concerns/problems?