



TEXAS COUNSELING

Individual, Couples, Family
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ADULT INTAKE FORM

Date of First Session:

Diagnosis:

Personal Data:

Date:

Name:

Address:

City:

Zip Code:

Telephone number: (day) (evening)

Email:

OK to leave message/text at above numbers? Yes No

Client's Social Security Number:

Client's DOB:

Age:

Occupation/Employer:

Marital status:

Who referred you?

With whom are you now living? (list people)

Where do you reside? ___house ___hotel ___room ___apartment ___other

Clinical Information:

What is happening in your life which resulted in this appointment?

Whom have you previously consulted about your present problem(s)?

Are you taking any medication? If “yes”, what, how much, and with what results?

What is there about your present behavior that you would like to change?

What feelings do you wish to alter (e.g., increase or decrease)?

What would you like to see accomplished in therapy? List at least 3 goals.

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
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