TEXAS COUNSELING
Individual, Couples, Family
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ADULT INTAKE FORM

Date of First Session: ______ Diagnosis: ______

Personal Data:

Date: ______

Name: ______

Address: ______

City: ______ Zip: ______

Telephone number: ______ (day) ______ (evening)

Email: ______

Preferred method of contact: ☐ Home ☐ Work ☐ Cell
Ok to leave message/text at above numbers? ☐Yes ☐No

DOB: ______ Age: ______ Occupation: ______

Employer: ______

Student Status (if attending school): ☐ Full-time ☐ Part-time

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.