Turning Point Women's Counseling and Advocacy Center

ADULT INTAKE INFORMATION

DO NOT leave any portion blank – If something does not apply, please write N/A

Client Name: _____ Date of Birth ____ /____ /____

□ Female S.S.# _____-____-_____

Address: _____ □Home Phone: _____

_____ □Work Phone: _____

_____ □Cell Phone: _____

Email: _____

Please check the phone number that should be used by the office staff for scheduling purposes

Status: □married □in domestic partnership □divorced □separated □never married □spouse/partner deceased

Employer: _____ Occupation: _____

Name, Age and Relationship of all individuals residing within your home (including parents or caretakers)

Name	Age	Relationship to Client

If known:

Primary Care Physician (PCP) _____ Medical Practice _____

Address_____ City _____ State _____ ZIP _____

Phone#: _____ Fax#: _____ Date of Last PCP Visit: _____

Allergies, medical conditions, disabilities _____

List all of your medications (office will copy personal list)

Name of Medication	Current Dosage/Frequency	Start Date of Medication

Name(s) of prescribing doctor(s): _____

Emergency Contact (please list an individual to contact if we cannot reach you)

Contact Person _____ Home _____ Work/Cell_____

COMPLETE QUESTIONS ON THE BACK OF THIS FORM

OVER →

DO NOT leave any portion blank – write-in or check N/A where applicable

List any professionals or agencies that have been involved with your mental health treatment ☐ **N/A**

Type of Service	Name of Professional / Agency	Approximate Dates of Service

FAMILY HISTORY

Psychological / psychiatric treatment: ☐ **N/A**

PERSON PROBLEM DATES PROVIDER OUTCOME

_____

_____

_____

Psychiatric hospitalizations: ☐ **N/A**

PERSON REASON FOR HOSPITALIZATION LENGTH OF STAY TREATING PHYSICIAN

_____

_____

_____

Medical problems and/or physical disabilities: ☐ **N/A**

PERSON PHYSICAL PROBLEM / DISABILITY TREATING PHYSICIAN

_____

_____

_____

Please initial all applicable problems that your extended family has experienced using the corresponding initials in the key below:

(M=Mother, F=Father, C=Child, SB=Sibling, G=Grandparent, A=Aunt, U=Uncle ,S=Self)

___ Alcohol
___ Family Violence
___ Legal Difficulties
___ Drug Addiction
___ Bi-Polar
___ Family Problems
___ Financial Difficulties
___ Mood Swings
___ Marital Relationship
___ ADD/ADHD
___ Depression
___ Physical Health
___ Emotional
___ Interpersonal Problems
___ Career Issues
___ Parenting
___ Work-Related Stress
___ Anxiety
___ Eating Disorder

_____

Do we have your permission to acknowledge to your physician your involvement in counseling? **YES** **NO**

_____ _____

Signature of Client Date

I give my permission for the office staff to contact me at the phone numbers/e-mail that I provided on this intake form and to leave messages regarding appointments, etc. Courtesy reminder calls/e-mails are available upon request. However, I understand that this service is a courtesy and scheduled appointments are the responsibility of me, the client.

_____ _____

Signature of Client Date