

Adult Information Form

Name: _____ Today's Date: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Age: _____ Gender: _____ Ethnic Background _____

Telephone: (home) _____ OK to leave message? Yes ___ No ___

Telephone (cell) _____ OK to leave message? Yes ___ No ___

E-mail address (if you want to use e-mail for communication) _____

Who can I call if there is an Emergency ? (Name someone you feel comfortable knowing you are in counseling)

Name: _____ Relationship _____

Phone # _____ Alternate # _____

Relationship Status: Never Married Married Divorced Separated Unmarried living with partner Widowed

Other: _____

Occupation (if employed): _____ Formal Education (if applicable): _____

Please describe the difficulties/issues that have brought you to see me:

What do you hope to have happen by coming to counseling: _____

Please rate the severity of your concerns: (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

Have you ever received psychological, psychiatric or counseling services before? Yes ___ No ___

If yes, please indicate approximately when, for how long and the reason for seeking services.

How helpful was it? Place X on scale _____
Very helpful Somewhat helpful Not at all helpful

Are you currently working with another therapist in any capacity? Yes ___ No ___

Name of Therapist _____

How did you locate my name? ___ Psychology Today ___ Good Therapy.org ___ Website ___ Referral ___ Other

If referred, who referred you? _____

May I contact this person or agency to acknowledge the referral? Yes ___ No ___