Family Service Agency
Strengthening Individuals & Families

Submit

Adult Intake Form

Client Name: Last_____ First_____ MI_____ Birth Date_____

Preferred Pronouns:_____

SSN_____ Phone: Cell_____ Home_____ Email_____

Address _____City_____ State _____ Zip _____

Employer _____Phone: _____

Preferred Contact: Home Cell Work Email Best Time to Contact: _____

Treatment History

Is the client currently or previously receiving mental health treatment? YES or NO If yes, where_____

Are you willing to sign a Release of information? YES or NO

Is the client on any medications?

Name of Medication	Purpose of Medication	Dosage	Effective?

Recent health problems and/or hospitalizations?

Date	Concern	Other

Do you have concerns about any of the following? *Please highlight*

Anger Management	Anxiety	Sexual Behaviors	Severe Mood Swings
Eating Problems	Fears	Hyperactivity	Behavioral Changes
Sleeping Problems	Depression	Alcohol/Drugs	Problems at School

Other:

_____

Household Information

Household size: _____ Household income: _____

Others Living in the Household:

Last Name	First Name	Age	Gender	Relationship to Client
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Person Completing Form: _____