



ADULT INTAKE

PERSONAL INFORMATION

Name _____

Address _____

City _____ Province _____ Postal Code _____

Phone _____ Cell _____

Email _____

Date of Birth _____

EDUCATION

Highest Grade you completed _____ College Student? Yes ☐ No ☐

What College _____

EMPLOYMENT

Do you work outside the home? Yes ☐ No ☐ Disability? Yes ☐ No ☐

Place of Employment _____

SPOUSE OR PARTNER INFORMATION

Name _____

Address _____

City _____ Province _____ Postal Code _____

Phone _____ Cell _____

Email _____

Date of Birth _____

EDUCATION

Highest Grade they completed _____ College Student? Yes ☐ No ☐

What College _____

EMPLOYMENT

Does your Spouse or partner work outside of the home? Yes ☐ No ☐

Disability? Yes ☐ No ☐

Place of Employment _____

CHILDREN

Children _____

Names and Ages _____

Where do they live today?

Emergency Contact Person _____

Relationship to you _____ Phone _____

FAMILY BACKGROUND

Mother _____

City _____ Province _____

Occupation _____

Father _____

City _____ Province _____

Occupation _____

Siblings (name and age) _____

Did anyone else raise you? (Nanny, Auntie, Grandmother etc.) _____

Why? _____

HISTORY

List all of the places that you lived:

Which one was favorite _____

Which one was your least favorite _____

ABOUT YOU

List your favorite activities:

What brings you joy?

What is your least favorite thing to do?

List your fears

Have you ever been to Therapy before? Yes ☐ No ☐

Length of time _____

What do you hope to accomplish in therapy?

Were you: (in your childhood and/or as an adult)

Sexually Abused _____

Physically Abused _____

Verbally Abused _____

Psychologically Abused _____

Ritually Abused _____

What Medications are you currently taking:

What Herbal remedies are you currently taking:

How do you cope with stress?

Do you have a problem with Porn? _____

Would your partner or family agree with you? Yes ☐ No ☐

Do you have a problem with Drinking? _____

Would your partner or family agree with you? Yes ☐ No ☐

Do you have a problem with drugs? _____

Would your partner or family agree with you? Yes ☐ No ☐

Do you have a problem with cutting? _____

Would your partner or family agree with you? Yes ☐ No ☐

Do you have a problem with an eating disorder? _____

Would your partner or family agree with you? Yes ☐ No ☐

Do you have a gambling or spending problem? _____

Would your partner or family agree with you? Yes ☐ No ☐

Is there a reoccurring complaint about you that a partner, spouse, or family member makes?

How are you feeling?

Have you ever been in a 12 Step Program? Yes ☐ No ☐

Which one? _____

Have you ever admitted yourself or been admitted to:

- ☐ Inpatient Psychiatric Facility
- ☐ Drug and Alcohol Treatment Facility
- ☐ Detox Center
- ☐ Eating Disorder Treatment Facility
- ☐ Other Treatment Facility (DID, PTSD, Gambling, etc)

What is your drug of choice? _____

What is your fall-back addiction? _____

How long have you been clean and sober? _____

Do you have a sponsor? Yes ☐ No ☐

Have you ever attempted Suicide? Yes ☐ No ☐

When? _____

Were you hospitalized? Yes ☐ No ☐

Where? _____

Are you suicidal now? Yes ☐ No ☐

If so, what is keeping you alive at present?