Adolescent and Family Counseling Services, LLC

ADULT / CHILD INTAKE FORM

Name: _____ Age: _____

Gender: _____ Date of Birth: _____

Parent / Legal Guardian Name: (if under the age of 18) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Health Insurance / number: _____

Social Security Number: _____

Mental Health History

Have you received counseling / treatment under the care of a Psychiatrist or psychologist?

Are you now receiving counseling / treatment _____ if yes, name of doctor / facility

Reason for seeking counseling:

Are you taking any medication? _____ If yes, what kind?

Work / School History

Name: _____ (Grade) _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

Emotional Status

Are you currently experiencing thoughts of self harm? _____ if yes, describe;

How long has this been a problem for you?

Do you exhibit physical aggression (hitting, pushing, kicking, bullying, breaking items, holes in walls,
ect.)?

Do you exhibit verbal aggression (screaming, cursing, threatening, etc.)?

Do you have any physical limitations that will prohibit you from being safe at Adolescent and Family Counseling Services, LLC? (i.e. wheel chair accessibility)

Agency Representative: _____ Date _____