Let's Talk
Therapy and Supervision

ADULT INTAKE FORM

Please provide the following information for your records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as therapy. Please fill out this form and bring it to your first session or allow yourself fifteen minutes prior to your appointment to complete the form in the office.

ABOUT YOU
Your Name:

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ **Age:** _____
Gender: □ Male □ Female □ Transgender
Marital Status:
□ Minor/Child □ Never Married □ Partnered □ Married □ Separated
□ Divorced □ Widowed

Local Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____

May we leave a message? □ Yes □ No

313 N. Seneca St., Ste. 117 – Carriage House Office Park
Wichita, KS 67203-5951
Angela@letstalkwichita.com
316.804.5135 v 316.847.7082 f

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Cell/Other Phone: ( ) _____

May we leave a message? □ Yes □ No
May we send text messages? □ Yes □ No

E-mail: _____

May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Preferred form of contact? (Please Circle)
Text Email Phone call/Voicemail
Appointment reminders are sent via email

What are your goals for therapy (i.e. How will you know that therapy is helping you)?

Do you have a guardian and/or conservator? □ Yes □ No

If "Yes," please provide his/her name and contact information:

Do you have children? □ Yes □ No If so, note how many children and their ages:

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REASON FOR SEEKING HELP?

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HEALTH AND SOCIAL INFORMATION

How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

If you are prescribed any medications for physical/medical conditions, please list them:

May we communicate verbally and share written information with your primary care provider? □ Yes □ No **If Yes, name and telephone number of your PCP:**

Are you having any problems with your sleep habits? □ Yes □ No
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other:

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Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting □ Purging

Have you experienced significant weight gain or loss in the last 2 months?
□ No □ Yes
If, so how many pounds?

Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

How often do you engage in recreational/illegal drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

Alcohol/Substance Abuse? □ No □ Yes

If yes, drugs/alcohol of choice:

Have you received outpatient or inpatient treatment services for alcohol or drug abuse or addiction? □ No □ Yes

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Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship?

On a scale of 1-10, how would you rate the quality of your current relationship? Add any details:

In the last year, have you experienced any significant life changes/stressors/traumatic events:

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YOUR MENTAL AND EMOTIONAL HEALTH

Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had any past suicide attempts: □ No □ Yes
If Yes, When:

Have you ever experienced?

Extreme depressed mood: □ No □ Yes

Rapid Mood Changes: □ No □ Yes

Rapid Speech: □ No □ Yes

Impulsive or Risky Behaviors: □ No □ Yes

Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes

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Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Homicidal Thoughts: □ No □ Yes

Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes

Phobias: □ No □ Yes

Recurrent bad dreams/nightmares □ No □ Yes

Flashbacks: □ No □ Yes

Repetitive Thoughts (e.g., Obsessions): □ No □ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): □ No □ Yes

Frequent Body Complaints□ No □ Yes

Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes

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Are you *currently* receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

If Yes, where?

Have you had *previous* psychotherapy/counseling? □No □Yes

If Yes; previous therapist's/counselor's name and contact information:

Have you received inpatient behavioral health services? □No □Yes,

If Yes; name of facility(ies) and approximate dates:

Are you currently taking psychiatric/behavioral medication (antidepressants or others): □Yes □ No

If Yes, please list:

Prescriber(s) and contact information:

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If no, have you been previously prescribed psychiatric/behavioral medication? □Yes □No

If Yes, please list:

Prescriber(s) and contact information:

Are you or have you received any community based mental health services (i.e. case manager, attendant care worker, etc.)? □ No □ Yes

If yes, please explain:

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FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member(s), e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member(s)**
Depression □ No □ Yes	
Bipolar Disorder □ No □ Yes	
Anxiety Disorder □ No □ Yes	
Panic Attacks □ No □ Yes	
Schizophrenia □ No □ Yes	
Alcohol/Substance Abuse □ No □ Yes	
Eating Disorders □ No □ Yes	
Learning Disabilities □ No □ Yes	
Trauma History □ No □ Yes	
Suicide Attempts □ No □ Yes	
Other:	

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Have you ever been diagnosed with a mental health disorder? □ No □ Yes

If yes, please list diagnoses and any pertinent details

OCCUPATIONAL INFORMATION

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position and how long have you worked there?

If yes, are you happy at your current position? □ No □ Yes

Please list any work-related stressors:

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SCHOOL INFORMATION

Are you currently attending school? □ No □ Yes

If yes, where do you attend school, what is your current grade level in school and what degree are you seeking (if in college)?

Please list any school-related stressors:

What is the highest level of education you have completed?

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RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith?

If no, do you consider yourself to be spiritual? □ No □ Yes

If yes, please elaborate:

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MORE ABOUT YOU

What do you consider to be your strengths?

What do you like most about yourself or use three words or phrases to describe yourself?

What are your hobbies and/or interests?

Please share any other information which may be helpful:

Thank you for your time!

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