Solomon Family Services
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ADULT CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Date: _____

CLIENT INFORMATION

Patient Name: _____ _____ _____
(Last) (First) (Middle Initial)

DOB: __/___/__ Age:_____ SSN: _____

Address: _____

City: _____
Street City State Zip

Home Ph: _____ Work Ph: _____ Cell: _____

Employer: _____ Occupation: _____

Email:_____ Preferred contact number: Home Work Cell
Circle one

May we contact you?

May we leave a message? Yes____ No_____ If so where at: _____

Referred by: _____ Telephone Number: _____

Address: _____
Street City State Zip

Marital Status:

□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Spouse/Partner

Name: _____

Address: _____
Street City State Zip

Home Ph: _____ Work Ph: _____ Cell: _____

Email _____ Preferred contact number Home Work Cell
Circle one

Employer: _____ Occupation: _____

Number of Children: _____

Family Information (OR other household members)

Name	Sex M/F	Age	Grade/Occupation	At Home (Y/N)

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

Have you had previous psychotherapy? □Yes □No
If yes please list Previous therapist's name:_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No
If Yes, please list:_____
If no, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list: _____

Presenting Problem or Issue

Please describe the nature of your visit: _____

_____

_____

Describe any history of emotional, physical, and /or sexual abuse_____

_____

_____

Describe any significant stressors or life changes that have occurred in within the past two years (i.e. death of friend/loved one, marriage, divorce, separation, birth of child, changes in work, school, or residence):

_____

_____

_____

_____

_____

Health and Social Information

1. 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 _____

2. Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Binging □Restricting

3. Have you experienced significant weight change in the last 2 months? □ Yes □ No

4. Do you regularly use alcohol? □ Yes □ No

5. Have you ever had or are you currently having thoughts of

Hurting yourself	□ Yes □ No
Hurting someone else	□ Yes □ No

6. Have you seen a therapist for any of these issues in the past or present? □ Yes □ No

7. Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

8. Have you had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

Have you ever experienced:

Extreme depressed mood	□ Yes □ No
Wild Mood Swings	□ Yes □ No
Rapid Speech	□ Yes □ No
Extreme Anxiety	□ Yes □ No
Panic Attacks	□ Yes □ No
Phobias	□ Yes □ No
Sleep Disturbances	□ Yes □ No
Hallucinations	□ Yes □ No
Unexplained losses of time	□ Yes □ No
Unexplained memory lapses	□ Yes □ No
Alcohol/Substance Abuse	□ Yes □ No
Frequent Body Complaints	□ Yes □ No
Eating Disorder	□ Yes □ No
Body Image Problems	□ Yes □ No
Repetitive Thoughts (e.g., Obsessions)	□ Yes □ No
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	□ Yes □ No
Homicidal Thoughts	□ Yes □ No
Suicide Attempt	□ Yes □ No

If you have checked yes to any of the above mentioned items please explain:

_____

_____

FAMILY MENTAL HEALTH HISTORY:

Research has shown that heredity plays a role in many disorders. Please take time to think of your various blood relatives when answering the following questions.
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Relationship**	
Depression		□ Yes □ No
Bipolar Disorder		□ Yes □ No
Anxiety Disorders		□ Yes □ No
Panic Attacks		□ Yes □ No
Schizophrenia		□ Yes □ No
Alcohol/Substance Abuse		□ Yes □ No
Eating Disorders		□ Yes □ No
Learning Disabilities		□ Yes □ No
Trauma History		□ Yes □ No
Suicide Attempts		□ Yes □ No

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ Yes □ No
If yes, what is your faith? _____

OTHER INFORMATION:

What do you consider to be your strengths? _____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you've learned? _____

_____
__

What are your goals for therapy? _____

_____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

CLIENT'S SIGNATURE: _____ DATE: _____

COUNSELORS SIGNATURE: _____ DATE: _____