

Adult Intake

Demographic Information				
Name:		Date:		
DOB:	Age:	Sex:	Male	Female
Street Address:				
City:		State:	Zip Code:	
Best form of communication with you?		Phone Call	Text	Email Mail
Phone Number(s):				
<i>Is it OK to Text this number?</i>			<i>YES</i>	<i>NO</i>
<i>Is it OK to leave a voicemail?</i>			<i>YES</i>	<i>NO</i>
<i>Would you like to receive email communication?</i>			<i>YES</i>	<i>NO</i>
Email:				
<i>Is it ok to send something in the mail?</i>			<i>YES</i>	<i>NO</i>
How were you introduced to us?				
If you found us online what words did you search to find us?				

What Brought You Here?
<u>Prioritize</u> the 3 main concerns you have right and how long have each been going on?
1.
2.
3.
What are your loved one's concerns about you?
What solutions (helpful or unhelpful) have you tried to resolve the above concerns?
Have you had therapy in the past? With whom and when? Reasons? What was helpful? Unhelpful?

Spiritual Beliefs

Do you belong to any church, religious or spiritual groups, etc.?	NO	YES
If yes, which church/group?		
What is your level of involvement?	NONE	SOME
	MUCH	
To what extent do your religious/spiritual beliefs/practices influence you?		
	NONE	SOME
	MUCH	

Change is Coming...

What are your expectations from therapy?
What are your expectations of the therapist?
How will you know that our work together has been effective?
List concrete changes you might see:
What other changes would you like to see in your life? Family career health relationships
OTHER
What obstacles might prevent you from achieving your goals/changes?
How long do you think therapy will need to last to achieve your goals?
Write down a target date:
List 3 strengths about yourself or that others indicate you have...Examples of each:
1.
2.
3.
Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future? NO If so, who?

Important Questions We Must Ask

Are you currently suicidal?	NO	YES
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If yes, please explain:

Are you currently homicidal?	NO	YES
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If yes, please explain

Do you currently see or hear things others do not see or hear?	NO	YES
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Is the reason you are seeking therapy services substance related?	NO	YES
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Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful?	NO	If so, please explain:
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Do you have current legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?		
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Career/Job, Recreation and Leisure

What is your current occupation? How would you describe fulfillment in your job/career?

What is your highest level of education completed and field of study?

What do you enjoy doing during your free/leisure time?

Intimate Relationships

If you are currently in a relationship? NO YES

Describe your relationship:

How would you describe your communication?

How would you describe intimacy in your relationship?

If you are in a relationship answer the following regarding your relationship:

1. Like

2. Dislike

3. Not enough of

4. Too much of

5. Ideal relationship

Understanding Your Family & Influences

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

OTHER:

How would you describe your upbringing?

Who lives with you currently?

Describe your relationship with the following:

Mother:

Father:

Mother's Significant Other:

Father's Significant Other:

Siblings:

Age

Name

Children:

Spouse/Significant Other:

Relationships

Describe your relationship with your friends:

Who is your support system (people, organizations, or affiliations)?

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results.

Signature

Date

Signature Page for HIPAA, Therapy Agreement, Policies, Consent Forms

I have read and understand the following forms and understand that I may ask any questions about them. I understand that I may download them from the website (AdventHelp.com) anytime if I wish to store or print them for myself.

HIPAA

Therapy Agreement

Policies

Consent Forms

Signature

Printed Name

Date

Witness

Date



Payment Policy and Client Authorization

Should I, _____, not pay for services rendered or fail to meet my financial obligation to Advent Counseling as evidenced by neglect of payment for services rendered, I agree to and authorize Advent Counseling to debit my credit card account for the service or product provided and/or any balance due.

*As a means of holding myself accountable to Advent Counseling, I agree to provide the following current and active credit card information and do hereby authorize Advent Counseling to charge my card for the payments and/or remaining balance **in the event I should fail to uphold my agreement.** The charge is usually made the date of service.*

Credit Card Number: _____

Expiration Date: _____ Security Code Number: _____

Cardholder Billing Address of Credit Card Account:

Street Number _____

Zip Code _____

Notification Information:

Cardholder Phone Number: _____

Cardholder Email: _____

Client Signature

Date

ALL CREDIT CARD INFORMATION IS SECURED IN LOCKED FILES AND WILL BE SHREDDED AFTER ACCOUNT IS PAID IN FULL.