



# Adult Intake Form

## CLIENT INFORMATION

\_\_\_\_\_  
First Middle Last

\_\_\_\_\_  
Date of Birth Age Male/Female (Circle one)

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Address: Street

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Primary Phone Number Ok to Leave a Message? Yes No

\_\_\_\_\_  
Secondary Phone Number Ok to Leave a Message? Yes No

\_\_\_\_\_  
Emergency Contact Name Emergency Contact Phone Number

How did you learn about Encompass Mental Health?: \_\_\_\_\_

## INSURANCE

\_\_\_\_\_  
Health Insurance Provider Health Insurance ID/Group Number

\_\_\_\_\_  
Name of Policy Holder Policy Holder's Date of Birth

\_\_\_\_\_  
Policy Holder's SSN Relationship to Client

**BACKGROUND**

Marital Status (Circle One):

Single/Dating      Married      Divorced      Separated      Widowed      Other: \_\_\_\_\_

\_\_\_\_\_  
Spouse or Significant Other's Name

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Occupation

Previous Counseling Experience: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Briefly explain the reason for seeking counseling: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION**

\_\_\_\_\_  
Primary Care Physician

\_\_\_\_\_  
Hospital/Clinic Name

\_\_\_\_\_  
Date of Most Recent Exam/Physical

\_\_\_\_\_  
Medical Problems/Diagnoses

\_\_\_\_\_  
Medications

\_\_\_\_\_  
Unusual Health Background or Experiences?