

**Counseling and Consulting Associates of North Texas
Adult Intake Form**

Date _____

Referral Source _____

Client Contact Information

Name _____

Social Security Number _____

Date of Birth _____

Age _____

Address _____
Street City/State Zip Code

Email address _____

_____ Home phone _____

Permission to leave message yes no

_____ Cell phone _____

Permission to leave message yes no

_____ Work phone _____

Permission to leave message yes no

CCA makes courtesy calls to remind you of your scheduled appointment. Please put a check beside the phone number you would like us to use for these calls.

Place of Employment _____
Name City/State

Medical Information

Primary Care Physician _____

Gynecologist _____

Are you taking any medication at this time? If so, please list _____

Are you having difficulty with sleep? If so, please describe. _____

Have you experienced changes in your appetite or your eating habits? If so, please describe. _____

Are you currently under the care of a psychiatrist? If so, who and for how long? _____

Do you have any physical conditions which you would like the therapist to know? _____

Information Concerning You and Your Immediate Family

Your Marital Status _____

If married, spouse's name _____ Number of Years Married _____

Spouse's Age ____ Spouse's Place of Employment _____

If you are divorced, please list the names of previous spouse(s) and the number of years divorced.

Please list names and ages of your children:

Information Concerning You and Your Family Origin

Describe your relationship with your parents (step-parents, if applicable), both currently and in the past.

	Past	Present
Mother	_____	_____
Father	_____	_____
Step mother	_____	_____
Step father	_____	_____

Please list your siblings and their ages:

Is there a history of drug or alcohol abuse in your family? If so, please describe. _____

Is there a history of sexual abuse in your family? If so, please describe. _____

Is there a history of physical abuse in your family? If so, please describe. _____

Some Questions About You

Briefly describe what brings you to counseling now. _____

Has anyone in your family had counseling before? If so, who and for what reason?

Who are the people in your life who mean the most to you? _____

What is important to you? _____

If you have a problem, who are you most likely to share it with? _____

With whom do you enjoy spending time? _____

What are your interests? _____

What are your plans for the future? _____

What accomplishment are you most proud of? _____

What are three words you would use to describe yourself? _____

Do you use alcohol or drugs? If so, please describe _____

Have you ever experienced sexual difficulties? If so, Please explain. _____

What community resources, if any, are members of your family using? (twelve step programs, WIC, Hope's Door, City House, etc.)? _____

What else would you like your therapist to know about you – or about what brings you to counseling today?

Consent for Requesting Records:

If you would like for us to send for additional information, counseling records, or medical records, please fill in the information below:

To (your doctor or counselor)

Name

Address

Phone Number

FAX Number

Please send my medical /counseling records to:

Counseling and Consulting Associates of North Texas
2750 W Virginia Parkway, Suite 108
McKinney, Texas 75071
(972) 542-8144

Signature

Date