Living Vine Counseling, LLC

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ADULT INTAKE FORM

All information is strictly confidential

Today's Date:_____

Name: _____ Date of Birth_____: Age: _____

Address: _____

City, State, Zip Code _____

Occupation: _____

Please indicate which of the numbers you provide below is the best for us to call to confirm and to leave messages regarding your appointments:_____

Home: _____ Work: _____ Cell: _____

Email address: _____ Ok to email you? _____

Spouse's name: _____ Spouse's cell: _____

Do you have a spiritual affiliation?_____

List any other social activities or interests outside of your occupation:_____

_____

Referred By:_____

EMERGENCY CONTACT / RESPONSIBLE PARTY INFORMATION:

Name: _____ Relationship to patient:_____

Address (if different from above): _____ Phone:_____

**Please list all persons authorized to handle account issues:
_____

_____
_____

PERSONAL & FAMILY HISTORY

	If living	If Deceased

	Age	Health	Year & Age	Cause
Father				
Mother				
Brother(s)				
Sister(s)				
Spouse				
Son(s)				
Daughter(s)				

MEDICAL HISTORY

Name any medications to which you are allergic: _____

Are you taking any medicines, drugs, herbs, over-the-counter medications, or vitamins?
Yes ___ No ___

List by name and dose. Be SURE to include medicine for: heart, blood pressure, thyroid, pain, sleep, nervousness, depression, epilepsy, birth control, weight reduction or hormones:

_____
_____
_____

Medical Hospitalizations (list illness, year, and physician):_____
_____
_____
_____

Surgical Hospitalizations (list illness, year, and physician):_____
_____
_____

Other serious illnesses or injuries:_____
_____
_____

Previous Psychiatric Treatment (practitioner, year, type of treatment, and medication):_____

Current Stresses:_____

Reason/Goals for Counseling:_____

Please indicate if you had any of these experienced any of the following in the past 3 months:

Depressed mood?				Sleep disturbance?		
Loss of interest?				Panic attacks?		
Loss of pleasure?				Excessive muscle tension?		
Excessive fatigue?				Excessive nervousness?		
Loss of appetite?				Difficulty breathing/smothering?		
Thoughts of self harm?				Feeling very slowed down?		
Thoughts of harming others?				Dizziness/Faintness?		
Trouble concentrating?				Tremors?		
Weight gain?				Sweating?		
Weight loss?				Tingling/Numbness?		
Agitation?				Flushes/Chills?		
Feelings of unreality?				Fear of losing control?		
Inappropriate elation?				Hallucinations (seeing or hearing things)?		
Inappropriate irritability?				Suspiciousness of several people?		
Grandiose notions?				Overly rapid/Skipping heartbeat?		
Increased pressured speech?				Difficulty remembering/Mind going blank?		
Disconnected, racing thoughts?				Unwanted recurrent persistent thoughts?		
Markedly increased energy?				Repetitive behavior or mental acts that you feel driven to perform?		
Distractibility?						
Impulse control problem?				Behaviors or thoughts aimed at warding off some dreaded event?		
Low self-esteem?						
Nervous habits?				Confusion?		

Social withdrawal?				Wide mood swings?	