



3069 Broad Street, Suite 7 D, Chattanooga, TN 37408, v/m: 423.517.7070 / fax: 423.208.9022

Confidential Information – Adult Intake

(Please Print)

Name _____ Today's Date _____
first middle or maiden last

Age _____ Date of Birth _____ Sex: Male Female Education _____

Home Address _____
street city state zip

Cell/Home Phone: _____ Email _____

Work Phone _____ Employer _____ Years _____

Work Address _____
street city state zip

**Please circle any information above that you DO NOT want me using to reach you OR to leave you a message.
I do not want to compromise your confidentiality or create an uncomfortable situation.**

Marital Status _____ Date of present marriage _____ Date(s) of previous marriage(s) _____

Spouse's name _____ Age _____ Education _____ Occupation _____

Employer _____ Years _____

Other Family Members Circle (M)ale or (F)emale.

Child(ren): _____	Age _____	M/F	Your Father _____	Age _____
_____	Age _____	M/F	Your Mother _____	Age _____
_____	Age _____	M/F	Brothers/Sisters: _____	Age _____ M/F
_____	Age _____	M/F	_____	Age _____ M/F
_____	Age _____	M/F	_____	Age _____ M/F
_____	Age _____	M/F	_____	Age _____ M/F
_____	Age _____	M/F	_____	Age _____ M/F

Former-Spouse _____ Age _____ Marital Status: S / REM / Div Years _____

Former-Spouse _____ Age _____ Marital Status: S / REM / Div Years _____

Physician / Internist / Gynecologist / Psychiatrist / Etc. (Doctor(s) seen routinely)

[1] Name _____ Ph. () _____ Years _____

Address _____ City _____ State _____ Zip _____

[2] Name _____ Ph. () _____ Years _____

Address _____ City _____ State _____ Zip _____

[3] Name _____ Ph. () _____ Years _____

Address _____ City _____ State _____ Zip _____

Do you have any current or ongoing medical problems, symptoms, hospitalizations? Please explain:

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Patient's name _____

CURRENT MEDICATIONS:

Taken as prescribed?

<u>Medication</u>	<u>Dosage</u>	<u>Yes</u>	<u>No</u>	<u>Doctor</u>	<u>Reason</u>	<u>How Long?</u>
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

Do you smoke or use tobacco? Yes No If yes, how much? _____ How long? _____

Do you drink alcohol? Yes No If yes, how much per: day/week/month/year? _____ How long? _____

Do you use non-prescription drugs? Yes No If yes, what kinds? _____ How long? _____

Does your family have a history of substance dependence or abuse? Yes No If yes, substance?

Previous Mental Health Services:

<u>Provider</u>	<u>Location</u>	<u>Dates of Service</u>

Current or expected legal involvement? Yes No **Current Order of Protection or Restraining Order?**

Yes No

If yes, please explain.

Referred by: _____ Friend/Doctor/Therapist/Agency/Church Phone: _____

May I have your permission to thank this person for their referral? Yes No Initials: _____

Emergency contact(s): _____ Relationship: _____ Phone: _____

Please provide your signature to indicate that I may contact them, if needed.

(Your Signature): _____

Religious affiliation: _____ Frequency of involvement/activities _____

Current level of satisfaction with your friends and social support: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Circle level

List your leisure interests and activities:

What do you consider to be your strengths?

Briefly describe the concerns and reasons that brought you here:

What you would like to achieve and/or see happen by coming here for care:
