Valencia Relationship Institute

28494 Westinghouse Place, #213, Valencia, Ca. 91355

ADULT INTAKE FORM

This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential.

BACKGROUND INFORMATION Date:___________________

Client's Name: ____________________________________ Date of birth __________ Age: ____

Address/City/Zip Code: ____

Home phone: ___________________________ Cell phone:____

Employer: __________________________________ Work phone: ________________________________

How long have you worked there? _________________

Previous Counseling / Therapy? _____ (If yes, with whom and for how long?)

____

Emergency contact: ____ Phone _______________

Who may I thank for referring you to my office today?

____

INFORMATION ABOUT CLIENT'S SPOUSE/PARTNER

Name: ____ BD:_________________ Age:___________

Address: (if different from patient) ____

Home phone: (If different from patient) ____

Cell phone: ________________________

Employer: _______________________________________ Occupation: __________________________

Work phone / Ext. _______________________

FINANCIALLY RESPONSIBLE PERSON´S INFORMATION:

Name: ________________________________Relationship to Client:________________

Phone: (if different from above)___________________________________

Address: (if different from above)__________________________________

MEDICAL HISTORY

Name of Physician_____________________________ Phone #_________________________

Date of Last Physical Exam: _____________________

Are you currently being seen by a psychiatrist?

If yes, name of psychiatrist: _______________________________ Phone #________________

Current Medications: ____

Are there any current medical conditions that we need to be aware of at this time?

____

DESCRIBE THE CONCERNS FOR SEEKING TREATMENT:_____________________________

____

____

LIST 3 GOALS YOU WOULD LIKE TO SEE ACHIEVED THROUGH COUNSELING:

1.____

2.____

3.____