

Valencia Relationship Institute

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

ADULT INTAKE FORM

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. _____