Austin Wellness, PLLC
www.austin-wellness.com
10010 Anderson Mill Rd.
Austin Texas 78750
512-257-0050

ADULT INTAKE FORM

All information you provide here is held to the same standards of confidentiality as our therapy.
Leave blank any question you would rather not answer. Please fill out this form prior to our first session.

Client Name: _____ Date: _____

Address: _____ City: _____ Zip Code: _____

Age: _____ Birth Date: ____/____/_____

We cannot guarantee confidentiality when you are communicating via cell phone, cordless phone, fax, email or computer. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when / where / how to use this technology.

Phone #: _____ May I leave a message? Yes | No

Preferred email contact: _____

Name(s) & age(s) of child(ren): _____
Emergency contact: _____Relationship: _____ Phone #: _____
Who referred you to me? _____ May I thank this person for the referral? Yes | No

Employer/Occupation: _____
Employment Status: Full-time | Part-time | Choose to stay at home | Unemployed
Are you happy at your current position? _____
Please list any work-related stressors: _____
Education completed: _____

What concerns lead you to therapy at this time?_____
_____

What goals do you have for therapy? _____

Are you currently receiving psychiatric care or psychotherapy elsewhere? Yes | No
If Yes, with whom? _____
Please describe any previous therapy experience: _____

Are you currently taking prescribed psychiatric medication (antidepressants, etc)? Yes | No
If Yes, please list:_____
Please list medications taken in the past:_____
Have you ever been hospitalized for psychiatric reasons? Yes | No
If yes, please describe: _____
Have you had suicidal thoughts? If yes, please describe: _____

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HEALTH AND SOCIAL INFORMATION

Please list any persistent physical symptoms or health concerns:_____
Current medications: _____
Primary care physician: _____ Phone #: _____

Are you having any problems with sleep? _____

What are your exercise habits? _____

Are you having any difficulty with appetite, weight or eating habits? Yes | No
If yes, please describe: _____

Do you smoke or use tobacco? Yes | No
If yes, please describe: _____

Do you drink alcohol? Yes | No If yes, please describe: _____

Do you use other/recreational drugs? Daily | Often | Rarely | Never | Not any more
If at all, please describe: _____

Have you ever experienced a concussion or other head injury? If yes, please list date(s) and information known: _____

Current relationship status: Single | Dating | Separated | Living together | Married | Divorced | Widowed

If applicable, please describe the quality of your current relationship: _____
_____

Please describe your relationship history: _____

Which of the following have you experienced or noticed in yourself in the **past year**?
(check all that apply)

__ Chronic Pain or Illness
__ Compulsive or Impulsive Behaviors
__ Family or Parenting Conflict
__ Grief/Loss
__ Legal Problems
__ Major Life Change
__ Sexual Dysfunction
__ Spiritual Confusion
__ Concentration or Memory Difficulty
__ Educational Problems
__ Financial Problems
__ Identity Confusion
__ Loneliness
__ Restlessness
__ Social Discomfort/Shyness
__ Trauma or disturbing life experience
Other (specify): _____

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FAMILY AND MENTAL HEALTH HISTORY

Check if yes:	Who?	Received treatment?
__ Depression	_____	Yes | No
__ Bipolar Disorder	_____	Yes | No
__ Anxiety Disorders	_____	Yes | No
__ Panic Attacks	_____	Yes | No
__ Schizophrenia	_____	Yes | No
__ Addiction	_____	Yes | No
__ Eating Disorders	_____	Yes | No
__ Learning Disabilities	_____	Yes | No
__ ADHD	_____	Yes | No
__ Trauma/Abuse History	_____	Yes | No
__ Suicide Attempts	_____	Yes | No

Briefly describe your relationship with your:
Mother:_____
Father: _____
Sibling(s): _____
Extended family:_____

Do you consider yourself to be religious? _____ If yes, what is your faith?_____
If no, do you consider yourself to be spiritual? _____
Do you feel that your faith should be a significant part of your therapy? Yes | No
Please describe: _____

What do you consider to be your strengths?_____
What do you like most about yourself?_____
How do you typically cope with problems in your life? _____

Client Name (Print): _____ Signature: _____ Date: _____

Signature of Therapist: _____ Date: _____