Full Circle Therapy Center, PLLC
Nicole Siegel, LCSW, LCDC

Adult Intake Form and Identifiable Information

Name_____ Date_____

Address _____ Apt_____

City _____ State_____ Zip Code _____

E-mail_____Ok to contact _____Yes _____ No

Home Phone_____Ok to contact _____Yes _____ No

Cell Phone _____Ok to contact _____Yes _____ No

Date of Birth_____/_____/_____ Age_____ Gender:_____M_____F

Employer_____ Occupation_____

Number of different jobs in the past 3 years:_____Last Grade/School Completed_____

Social Security Number:_____-_____-_____

Marital Status:_____Single_____Married_____Separated_____Divorced_____Widowed

If married, separated, divorced, or widowed, how long:_____

Name of Spouse/Partner_____ Date of Birth_____/_____/_____

Have Children:_____Yes_____No If yes, how many children?_____

Name of Children/Others in the Household	Relationship	Date of Birth	Age	Lives with You?
_____	_____	_____	____	Yes / No
_____	_____	_____	____	Yes / No
_____	_____	_____	____	Yes / No
_____	_____	_____	____	Yes / No
_____	_____	_____	____	Yes / No

Physician Name_____ Date of last physical:____/____/____

Are you taking medication(s):___Yes___No If yes what type?

_____

_____

Any health
isssues:_____

_____

In Case of Emergency:

I authorize to contact_____Relationship_____

Phone Number_____Alternate Phone Number_____

How did you hear about us? (circle option) Friend/Family Our Website Psychology Today
Other_____

Have you ever been treated by a psychiatrist? _____Yes_____No

Have you ever been hospitalized for mental or chemical dependency treatment? _____Yes_____No

Have you seen another therapist in the past 24 months? _____Yes_____No

If yes, who did you see? _____

Was it helpful? _____Yes _____No

Please explain:

_____

_____

Have you ever attempted suicide? _____Yes_____No

If yes, when?_____

Briefly describe your reason for seeking counseling
services:_____

_____

_____

What kind of things have you tried so far to handle this
situation?_____

_____

Please place a number that best corresponds to the issue listed below: (rate those that apply)

NEVER RARELY SOMETIMES OFTEN ALWAYS
1 2 3 4 5 6 7 8 9 10

___ Abuse- physical

___ Abuse- neglect

___ Anger, hostility, irritable

___ Career concerns, goals choices

___ Compulsions

___ Custody of children

___ Depression

___ Drug Use (illegal)

___ Gambling

___ Guilt

___ Judgment

___ Memory problems

___ Obsession/compulsion

___ PTSD

___ Sexual Issues

___Suicidal thoughts

___Thought disorganization

___Abuse-sexual

___Aggression, violence

___Anxiety, nervousness

___Co-dependence

___Cruelty to animals

___Decision-making, indecision

___Divorce, separation

___Eating problems

___Grieving

___Headaches

___Loss of control

___Menstrual, PMS, menopause

___Panic/anxiety attacks

___School problems

___Sleep problems

___Tobacco use

___Work problems

___Abuse-emotional

___Alcohol use

___Attention, distraction

___Confusion

___Crying, sadness

___Delusions (false ideas)

___Drug use (prescribed)

___Financial

___Goals

___Impulsiveness

___Marital/partner

___Mood swings

___Parenting

___Self-esteem

___Stress

___Temper/low tolerance

Other:_____

In the past 36 months has there been a death of a family member or someone close to you?

___Yes ___ No If yes, who?_____When_____Relationship:_____

Prior to the 36 months, has there been a death of someone that was close to you?

___Yes ___ No If yes, who?_____When_____Relationship:_____

Please rate below on a scale of 1 through 10, 1=not at all, and a 10=very much so:

___I was very close and had a good relationship with my father.

___I was very close and had a good relationship with my mother.

___I was very close and had a good relationship with my siblings.

___I have several good friends.

___I often have nightmares.

___I enjoy spending time alone.

___I have a tendency of agreeing with people to avoid confrontations.

___I don't like being around other people, I want to be alone.

___I like myself.

___I have a healthy interest in sex.

___I sometimes am confused with my identity.

___I put the needs and wishes of others first before myself even if I am not comfortable with it.

___I think I am responsible for the way others feel and their behaviors.

___I drink alcoholic beverages at least 3 times per week.

___I have a problem saying "no".

___Others can make me mad, frustrated, disappointed, or sad easily.

Fears or concerns of counseling:

_____

Goal or expectation of counseling:

_____