Melanie Stone, PhD HSPP

ADULT CLIENT INTAKE FORM

Name:_____ **Date of Birth:**_____

Address:_____ **City/State/Zip:**_____

Primary Phone: _____ **Email:**_____

Occupation:_____ **Employer:**_____

I give Dr. Stone permission to contact me by: ☐ Phone call ☐ Voicemail ☐ Text ☐ Email

Education (highest level attained):

_____

Spouse/Partner Name: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Date of last visit: _____

Please list any significant health problems:

_____

_____

Please list any medications you are taking and who prescribed them:

_____

Have you had counseling or psychotherapy previously? ☐ Yes ☐ No

If yes, when and with whom?_____

Religious/spiritual background or affiliation, if relevant to you:

_____

Please check any concerns that are affecting you now:

☐ Worry/anxiety
☐ Panic attacks
☐ Social discomfort
☐ Racing heart
☐ Poor appetite
☐ Headaches
☐ Sleep disturbance
☐ Obsessive thoughts
☐ Feeling fearful
☐ Outbursts of temper
☐ Marital/partner concerns
☐ Grief/loss
☐ Sadness/depressed mood
☐ Hopelessness
☐ Crying easily
☐ Fatigue
☐ Feeling inferior
☐ Poor concentration
☐ Poor memory
☐ Health concerns
☐ Problems at work
☐ Irritability/anger
☐ Family/friend relationships
☐ Trauma-related symptoms
☐ Religious/spiritual concerns
☐ Difficulty making decisions
☐ Flashbacks
☐ Disturbing memories
☐ Bad dreams/nightmares
☐ Loss of interest or pleasure
☐ Thoughts of harming others
☐ Thoughts of death
☐ Self-harm behaviors
☐ Alcohol/drug use
☐ Parenting concerns
☐ Other

What are the main reasons you are seeking counseling at this time?

_____

_____

What changes do you hope to see as a result of counseling?

_____

_____

Have you experienced significant trauma, loss, or other difficult life events that may be relevant to therapy? *(Please share only what you feel comfortable including here.)*

_____

_____

_____

In general, how would you describe your years growing up in your family home?

_____

_____

Is there a history of mental health problems in your family? ☐ Yes ☐ No ☐ Unsure

If yes, which family members and what concerns were present?

_____

_____

Are any of those family members currently taking medications for those concerns?

☐ Yes ☐ No ☐ Unsure

If relevant, please explain:

_____

Referral Information

How were you referred to Dr. Stone?

_____

Optional referral-source acknowledgment: If appropriate, I give Dr. Stone permission to let my referral source know only that I followed up on the recommendation for services. ☐ Yes ☐ No

Client signature: _____ Date: _____

Questions for Dr. Stone

Do you have any questions or concerns you would like to discuss today?

_____

_____