SANDBAR

PSYCHOLOGICAL SERVICES

ADULT INTAKE FORM

Personal Information

Full Name: _____

Date of Birth: _____

Age: _____

Gender: _____

Address: _____

Contact Details

Phone Number: _____

Email Address: _____

Preferred Method of Contact: ☐ Phone ☐ Email

Emergency Contact Name: _____

Emergency Contact Phone: _____

Relationship: _____

Medical Information

Primary Care Physician: _____

Physician Phone Number: _____

Current Medications:

_____

Allergies: _____

Past Medical Conditions/Surgeries:

_____

_____

Mental Health / Counseling Information

Reason for Seeking Services:

_____

_____

Have you previously received counseling or therapy? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Current Symptoms or Concerns

☐ Anxiety
☐ Depression
☐ Stress
☐ Relationship Issues
☐ Sleep Problems
☐ Other: _____

Lifestyle Information

Occupation: _____

Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Do you use tobacco products: ☐ Yes ☐ No

Alcohol Use: ☐ None ☐ Occasional ☐ Regular

Exercise Frequency: ☐ None ☐ 1-2 Times/Week ☐ 3-4 Times/Week ☐ Daily

Consent & Signature

I certify that the information provided is accurate to the best of my knowledge.

Signature: _____

Date: _____