Moosilauke Counseling Solutions Adult Intake Form

Date: _____

Demographic Information

Client's Name (First, MI, Last): _____

Preferred Name or Nickname: _____

Date of Birth: _____

Age: _____

Biological Sex: _____

Preferred Sex: _____

Mailing Address: _____

Physical Address (if different from above): _____

Please DO NOT list any numbers where you do not want to receive calls and/or messages

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

What is the best way for us to reach you (phone or email): _____

Marital Status (single, married, separated, divorced, widowed): _____

Children's Names and Ages: _____

Occupation: _____

Employer: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Preferred Phone Number: _____

Preferred Hospital Name: _____

Preferred Hospital Phone Number: _____

Insurance Information

Primary Insurance Company: _____

ID Number: _____

Group Number: _____

Secondary Insurance Company: _____

ID Number: _____

Group Number: _____

Medical History

Primary Care Provider Name: _____

Primary Care Provider Phone Number: _____

Allergies: _____

Current Medications (name, reason, and prescribing provider):

_____

_____

_____

Current Medical Issues: _____

_____

_____

Have you ever had any of the following health issues:

Seizures or convulsions Yes _____ No _____ if yes please list date: _____

Head injury (specify if with or without loss of consciousness) Yes _____ No _____

If yes please list date: _____

Asthma Yes_____ No_____

Heart Condition (including murmurs) Yes _____ No _____

If yes, please list condition: _____

Serious infection or injury Yes _____ No_____

If yes, please describe: _____

Surgery Yes _____ No _____

If yes, please describe: _____

Psychiatric History

Do you currently see a psychotherapist? Yes_____ No _____

Current Psychotherapist Name: _____

Current Psychotherapist Phone Number: _____

Have you ever seen a psychotherapist Yes _____ No _____

Former Psychotherapist Name: _____

Former Psychotherapist Phone Number: _____

Past psychotherapy treatment approaches tried (CBT, DBT, etc.…): _____

_____

Are you currently taking any medication for a psychiatric reason? Yes____ No ____

If yes, please list name, dosage, frequency, start date of medications, and prescribing provider:

_____

_____

If you have ever taken medication for a psychiatric reason please list name and reason for discontinuing:

_____

_____

Have you ever been hospitalized for a psychiatric reason? Yes _____ No _____

If yes, please list hospital and reason for hospitalization: _____

_____

Family History

Is your father living or deceased (if deceased list cause): _____

Is your mother living or deceased (if deceased list cause): _____

Names and ages of siblings: _____

Please list any known medical and psychiatric history within your family (including extended family):

_____

_____

_____

Treatment

In a sentence or two, please tell us your reason(s) for seeking help: _____

_____

_____

Please tell us what you hope to gain from treatment: _____

_____

_____

Please tell us if you are looking for any specific treatment approaches: _____

_____

_____

Please tell us any fears you have about seeking help: _____

_____

_____

Anything else you think we should know about you: _____

_____

_____

Are you looking for in-person or telehealth appointments? _____

What is your availability? _____