LIVE! LLC.
PO Box 35144
Albuquerque, NM 87176-5144
505-717-7227

Adult Intake Form

Name _____ Date of Birth _____

Phone: Home _____ Cell _____ Work _____

Gender _____ Marital Status: Married _____ Single_____ Other_____

Home Address: _____

_____
City State Zip Code County

Lives With: _____

Emergency Contact: _____

Relationship: _____

Email Address: _____

Who referred you? _____

Other Health Professionals involved in your care

_____

_____

Has Had Previous Therapy? Yes ____ / No _____

If yes, with whom? _____ _____
Name When?

Mental Health History:

Previous treatment (counseling, therapy, outpatient treatments, in-patient or partial hospitalizations):
_____

_____

_____

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Type of treatment Date Initiated Date Concluded Doctor or Therapist / Place

_____ _____ _____ _____

Are you currently in counseling / therapy elsewhere? Yes _____ No _____

If so, with whom and for what purpose?_____

_____

If you take medications for mental health purposes, please include them in the listing on the previous page.

Personal History:

Marital status _____ If married, date of marriage: _____
(married, single, widowed, etc.) (Month / Day / Year)

Name of spouse / partner _____

Children / Stepchildren:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any children deceased? _____ If yes, when? _____

Religious Preference: Congregation Attended _____

Other: _____

Previous marriages / committed relationships:
Dates and how terminated

_____

_____

Education:
Last grade completed / degrees or certificates earned

_____

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Employment:
Employer _____ Occupation / Position_____

Family of Origin:
Parents / Stepparents:

Name	Age	If deceased, when?	At what age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brothers / Sisters / Stepsiblings:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____

Any deceased? _____ If yes, who _____ When? _____

Briefly describe why you are seeking family services?.
_____
_____
_____

Check the items below that describe your concerns, feelings or situation:

___ Depression
___ Grief
___ Hopelessness
___ Worthlessness
___ Guilt
___ Suicidal thoughts / feelings
___ Anxiety
___ Panic attacks
___ Disturbing thoughts or images
___ Emotional / physical / sexual abuse
___ Memory problem
___ Alcohol / drug use
___ Impulsiveness
___ Seeing / hearing things others don't see / hear
___ Sleep problem
___ Eating problem
___ Sexual concerns
___ Marriage / relationship / family problems
___ Job / work / career problems
___ Friendship / peer relationship problems
___ Legal problem
___ Energy level too high
___ Energy level too low
___ Irritability
___ Anger
___ Difficulty concentrating
___ Behavior problems
___ Financial situation
___ Effects of earlier experiences on current functioning / relationships