**Tandem Adult Intake Form**

\* indicates a required field

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\* Client's Name:



\* Select Date:



Types of therapy you are interested in (select all that apply), please note this is just generating your interest in one or more types of therapy, and does not indicate treatment you are agreeing to.

Individual

Couples/Marital

Group

Family

**Family Relationships**

\* Marital Status (please select all that apply):

Single

Married/Partnership

Divorced

Separated

Other Status:

Please describe any important information about your relationship you would like the therapist to know.



\* Describe your current living situation. Do you live alone, with others, with family, etc...



If you have children, please list child's name, age and living situation?



\* Where were you born?



\* Describe who you were closest with in your family, growing up?



\* Describe your environment growing up (include family events such as divorce/abuse/death)?



Have you ever been sexually, emotionally, or physically abused? If yes, please briefly describe and include if it was reported to child services/police/not reported and date reported:



**Emergency Contact**

Emergency Contact: In the event of an emergency during a session, or life threatening crisis, the therapist can contact an emergency designee and may choose to follow up with 911 emergency services. If a life threatening emergency occurs (in person/on phone/in text) and the therapist determines that the client may harm themselves/someone else, they will contact emergency services, and may reach out to your emergency contact to inform them of the situation. By listing this person as your emergency contact, you are consenting to emergency information being given to them in a crisis situation.

Name of Emergency Contact:

Relationship to Client:

Phone Number:

Would you like a consent to release information for this person? \*Additional document will be required\*

**Health and Wellness**

Who is your primary care physician? Please include type of MD, name and phone number.

Name of Physician:

Phone number of Physician

Would you like to fill out a consent to release form for this person?

Please list medications and/or supplements you are taking, their dosage, frequency, reason you taking them, and prescribing doctor.



Do you use recreational drugs?

Yes

No

Do you drink alcohol?

Yes

No

Is there a history of mental illness in your family (include depression, anxiety, panic attacks, compulsions, post traumatic stress disorder, alcohol/drug addiction, bipolar, schizophrenia, ADHD, suicide attempts/ideation, homicidal attempts/ideation, psychiatric hospital stay). Please list the family member (mother, father, sister/brother...etc) and the type of history they had:



Have you ever been diagnosed with a mental illness before, if yes, please list below:



Do you use self-harm as a coping skill? If yes, please describe:



Do you have suicidal thoughts?

Yes

No

Have you ever attempted suicide?

Yes

No

Have you ever been hospitalized for a psychiatric issue?

Yes

No

Do you have thoughts or urges to harm others?

Yes

No

Please check any of the following you have experienced in the past six months

Increased appetite

Decreased appetite

Trouble concentrating

Difficulty sleeping

Excessive sleep

Low motivation

Isolation from others

Fatigue/low energy

Low self-esteem

Depressed mood

Tearful or crying spells

Anxiety

Fear

Hopelessness

Panic

Stress

Issues with body image

Irritability

Compulsions

Uncontrollable Anger or Rage

Nightmares

Loneliness

Affair

Nightmares

Abuse

Grief

Stomach Problems

Career Issues

Problems with Relationships

Self-Control

Trust

Financial Problems

Sleeping Problems

Pregnancy

Restricting Food Intake

Restricting Food & Purging

Binge Eating Episodes

Other

Please check any of the following health conditions that apply:

Headache

High blood pressure

Gastritis or esophagitis

Hormone-related problems

Head injury

Angina or chest pain

Irritable bowel

Chronic pain

Loss of consciousness

Heart attack

Bone or joint problems

Seizures

Kidney-related issues

Chronic fatigue

Dizziness

Faintness

Heart valve problems

Urinary tract problems

Fibromyalgia

Numbness & tingling

Shortness of breath

Diabetes

Hepatitis

Asthma

Arthritis

Thyroid issues

HIV/AIDS

Cancer

Other

Please list any other medical conditions of which we should be made aware:



Please list any allergies of which we should be aware (please include sensitivities to scents):



List all prior surgeries and medical illness hospitalizations:



**Education and Employment**

What is your level of education? Highest grade/degree and type of degree (include certifications/training):



What is your current occupation? What do you do? How long have you been doing it?



Do you feel like you need help with career guidance?



**Counseling Goals and Experiences**

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can



How long has this been a concern (best guess)?



In what setting(s) does the concern appear (list all that apply; example: church/school/home...etc):



Was there a time when this concern wasn't present? If yes, please describe:



What are your goals for counseling?



Have you seen a mental health professional before? If yes, please specify the dates/time-frame you went, the reason you went, and your experience, including what did/didn't work:



\* Do you participate in any support groups? If yes, please list below:



What have you found that has been helpful in relieving stress?



Please list any family/personal/religious/cultural values of which your therapist should be aware:



Please list what you think may be different after therapy (example: symptom relief, less fear...etc):



What else would you like me to know?



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