Coastal Virginia Counseling
Helping you reach your best

3500 Virginia Beach Blvd
Suite 440
Virginia Beach, VA 23452
Phone: (757)606-0015
Fax:(757)544-9880

ADULT INTAKE FORM

---------- Part 1 – To be completed by Client. ----------

CLIENT INFORMATION

Today's Date: ____/___/____ Referred By_____

Client's Name:_____

Date of Birth: ____/___/____ Age: _____

Client's Address: _____

City: _____ Sate: _____ Zip:_____

Phone (Home)_____ (Work)_____

Phone (Cell) _____(Cell 2) _____

E-mail: _____

Occupation: _____

Employer: _____

Marital Status: ☐ Married ☐Engaged ☐Widowed ☐Divorced

☐Separated ☐Live with Partner ☐Other _____

Name of spouse: _____

Do you attend church? ☐Yes ☐No

Church Name: _____

EMERGENCY CONTACT

Name: _____

Phone Number _____

Relation: _____

MENTAL HEALTH TREATMENT

Have you seen a therapist/counselor? ☐Yes ☐No

Therapist/Counselor Name:_____

Have you seen a psychiatrist? ☐Yes ☐No

Psychiatrist Name: _____

Have you had a previous mental health diagnosis? ☐Yes ☐No

If Yes: _____

MEDICAL AND PERSONAL

Primary Care Physician: _____

Office Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Specialist: _____

Type of Physician: _____

Office Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

FAMILY COMPOSITION

Who currently resides in the same house as the? Please include Family members as well.

Name	Age	Relationship
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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CURRENT MEDICATION PRESCRIBED

Name of Medication	Dosage	Frequency	Treatment for

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- ☐ Depressed
- ☐ Restlessness
- ☐ Overeating
- ☐ Withholding food
- ☐ Confusion
- ☐ Nausea
- ☐ Hallucinations
- ☐ Upset bowels
- ☐ Heart Racing
- ☐ Lack of energy
- ☐ Racing thoughts
- ☐ Stomach aches
- ☐ Indecisiveness
- ☐ Dizziness
- ☐ Self mutilation
- ☐ Poor memory
- ☐ Chest pains
- ☐ Violent behaviors
- ☐ Guilty conscience
- ☐ Seizures or convulsions
- ☐ Anxiety or nervousness
- ☐ Feelings of unreality
- ☐ Heart irregularities
- ☐ Feelings of sadness
- ☐ Addicted to pornography
- ☐ Feelings of worthlessness
- ☐ Suicidal thoughts
- ☐ Always “on guard”
- ☐ Excessive guilt or shame
- ☐ Unusual sexual behavior
- ☐ Feelings of loneliness
- ☐ Headaches
- ☐ Periods of “going blank”
- ☐ Sleeping to much
- ☐ Outbursts of anger
- ☐ Inability to sleep
- ☐ Shortness of breath
- ☐ Financial difficulties
- ☐ Difficulty making choices
- ☐ Uncontrolled crying spells
- ☐ Loss of consciousness
- ☐ Weight loss/gain
- ☐ Involuntary body trembling
- ☐ Loss or decrease of sex drive
- ☐ Tingling or numbness
- ☐ Excessive sweating
- ☐ Sensitivity to criticism
- ☐ Fear of “going insane”
- ☐ Fear of being alone
- ☐ Recurrent thoughts or worries
- ☐ Feeling compelled to do things
- ☐ Trouble getting along with others
- ☐ Avoiding people/social situations
- ☐ Neglected hygiene/appearance
- ☐ Weight loss by vomiting/laxatives
- ☐ Loss of interest in usual activities
- ☐ Difficulty thinking/distractions
- ☐ Preoccupation w/ bodily functions
- ☐ Difficulties at work or school
- ☐ Constant focus religious thoughts
- ☐ Moodiness, changeable moods
- ☐ Feeling as if reliving past trauma
- ☐ Excessive fear of persons, places
- ☐ Feelings of doom or death
- ☐ Recurring distressing dreams

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ADULT INTAKE FORM

PRESENTING PROBLEM

What brings you here today?

_____

_____

_____

_____

_____

_____

_____

_____

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