BEACON FAMILY CONSULTING
PLLC

Jenny Burnsed, MS LPC
☏ 303-882-8819
www.beaconfamilyconsulting.com

ADULT INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Today's Date: ____ / ____ / ____

PARENT INFORMATION:

Name: _____ Date of Birth: ____ / ____ / ____

Age: _____ Gender: ☐ Male ☐ Female

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone (Home) _____ (Cell) _____ (Work) _____

Is it okay to leave a message on your home phone? ☐ Yes ☐ No

Is it okay to leave a message on your cell phone? ☐ Yes ☐ No

Email Address: _____

Is it okay to communicate via email*? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

Continued

Have you previously received any type of mental health services?
(psychotherapy, psychiatric services, etc.)

☑ Yes ☐ No

Previous therapist/practitioner: _____

Are you currently taking any prescription medication?

☐ Yes ☐ No

Please list:

Have you ever been prescribed psychiatric medication?

☐ Yes ☐ No

Please list and provide dates:

It is considered best practice in the mental health field and with insurance providers for me to coordinate care with your primary medical provider. May I have your permission to coordinate care?

☐ Yes ☐ No

If yes, please list your primary care physician's name and contact information:

Continued

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

If yes, when did you begin experiencing this? _____

Continued

7. Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If yes, please describe :

8. Do you drink alcohol more than twice per week? ☐ Yes ☐ No

9. How often do you engage recreational drug use? ☐ Daily ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ Yes ☐ No If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. Have you experienced any life changing or stressful events recently? If so, please explain:

Continued

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse Anxiety	❑ Yes ❑ No	_____
Depression	❑ Yes ☐ No	_____
Domestic Violence	❑ Yes ☐ No	_____
Eating Disorders	❑ Yes ☐ No	_____
Obesity	❑ Yes ☐ No	_____
Obsessive Compulsive Behavior Schizophrenia	❑ Yes ☐ No	_____
Suicide Attempts	❑ Yes ☐ No	_____

Additional Info:

ADDITIONAL INFORMATION:

1. Are you currently employed? ❑ Yes ☐ No If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? ❑ Yes ☐ No
If yes, describe your faith or belief:

Continued

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?