Joelle Jacobson, M.A., M.F.T., P.P.S.
TEEN TALK LINE
855 – 411 - TEEN (8336)
JoelleMFT@TeenTalkLine.org
TeenTalkLine (SYKPE)
855 – 833 - 6411 (fax)

OFFICE USE ONLY

Dx Name:

Dx Number:

ADULT INTAKE FORM

Name:________________________________ Date:________________

Home Address:____
Street City Zip Code

Home Phone #:___________________ **E-Mail Address**:_________________

Cell Phone #:____________________ Work Phone #:__________________

Birth Date:______________

Employer:_________________________ Occupation:____________________

Marital Status:__________ If married, spouse's name:__________________

Education/Degree(s) completed:______________________________________

Previous Therapy:____
Therapist's Name Period of Time Therapy Issue(s)

Physician:________________________ Phone #:_______________________

Please describe your living arrangements:

_________________________ _____________________________
Name Age Relationship Name Age Relationship

_________________________ _____________________________
Name Age Relationship Name Age Relationship

In case of emergency, please notify:____________________________________

Relationship: ___________________ Phone #:__________________________

Who referred you to Teen Talk Line? ___________________________________

It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person (optional)**. No other information will be disclosed.

Signature:_______________________________ Date:_______________

Why are you seeking therapy at this time? ___________________________________

____

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____

Check any symptoms you have exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Weight Loss or Gain
___ Insomnia
___ Excessive Sleep
___ Feelings of guilt
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Rapid mood change
___ Risk-taking behavior
___ Argumentative
___ Nervousness
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Hallucinations
___ Delusions
___ Excessive Worrying
___ Nightmares
___ Fidgety
___ Excessive use of alcohol or drugs
___ Easily Distracted
___ Conflicts with peers, family, coworker
___ Grieving
___ Other (please describe): ____

List and describe any history of emotional disorder(s), physical and learning differences in your biological family:

____

____

____

____

List and describe any significant life events (e.g. divorce, death in family, terminal illness etc.):

____

____

____

List and describe any current or past physical concerns (e.g. ulcers, headaches, etc.):____

____

____

List and describe any drug and/or alcohol use: ______________________________

Date of your last physical? Blood work? ____________________________________

List any medication(s) and dosage you are currently prescribed: ________________

____

____

____

Prescribing Physician: ____________________ Phone: ___________________

Permission to speak with physician: _________________________ __________

Signature of patient Date

Permission to speak with psychiatrist: _________________________ __________

Signature of patient Date

What are your strengths and hobbies? _____________________________________

____

____

List your three primary treatment goals:

1. ____

2. ____

3. ____