

**Adult Intake Form**

**Dr. Monika Peterson**

**PLEASE COMPLETE IN BLACK INK ONLY**

**Monika Peterson, Ph.D., LLC**

**CLIENT CONTACT INFORMATION**

(\*By providing the following, you agree to being contacted by me through all provided forms of communication)

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Other/Maiden Names: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Sex: F M (Circle one) SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ EXT: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ May I leave a message on all voicemails? \_\_\_\_\_

Email Address: \_\_\_\_\_ Referred by: \_\_\_\_\_

Would you like appointment reminders via email? \_\_\_\_\_

(\*I am unable to provide phone call reminders)

Person responsible for bill: \_\_\_\_\_ Address: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**PRIMARY INSURANCE POLICY**

Insurance Company: \_\_\_\_\_ Policy holder: \_\_\_\_\_

Relationship to Policyholder: \_\_\_\_\_ ID Number (SSN for Tricare): \_\_\_\_\_

***\*\*Please have your card ready to copy.***

**SECONDARY INSURANCE POLICY**

Insurance Company: \_\_\_\_\_ Policy holder: \_\_\_\_\_

Relationship to Policyholder: \_\_\_\_\_ ID Number (SSN for Tricare): \_\_\_\_\_

***\*\*Please have your card ready to copy.***

**EMERGENCY CONTACT INFORMATION**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**GENERAL BACKGROUND**

Education (highest level completed): \_\_\_\_\_ High school(s) Attended (City, State) \_\_\_\_\_

If college educated, where? \_\_\_\_\_

Currently attending school? \_\_\_\_\_ If yes, specify where/how long attended \_\_\_\_\_

Current employer: \_\_\_\_\_ How long employed with current employer? \_\_\_\_\_

Current employment: Full Time Part Time If part time, specify \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: Never Married      Married      With Partner      Separated/Divorced      Widowed      (Circle one)

*If divorced or widowed, year* \_\_\_\_\_ *Previous Spouse's Name* \_\_\_\_\_

*If currently married, Spouse's Name* \_\_\_\_\_ *Age* \_\_\_\_\_ *Year Married* \_\_\_\_\_

*Spouse's Education* \_\_\_\_\_ *Occupation* \_\_\_\_\_ *Employer* \_\_\_\_\_

Children:

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Parents: Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Step-parents: Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

*(if applicable)* Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Siblings: Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Who lives in your home with you?

How would you rate your support system (spouse/partner, extended family, friends, co-workers)?

Excellent      Good      Fair      Poor      (Circle one)

About how many close friends do you have currently? \_\_\_\_\_

Military Service?      Yes      No      (Circle one)

If yes, please specify when and where

Religious preference? \_\_\_\_\_ Congregation attended? \_\_\_\_\_

To what ethnic group do you belong? (Please circle the most applicable group)

African-American      Anglo      Hispanic      Native-American      Other (Please provide)

Are you having any problems with your job or at school?      Yes      No      (Circle one)

If yes, please describe

What do you do for fun?

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**PHYSICAL HEALTH**

List current and past health problems, including operations, hospitalizations, and serious accidents or injuries. Please include approximate dates.

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Who is your Primary Care Provider (family doctor)? \_\_\_\_\_ Telephone number: \_\_\_\_\_  
Address? \_\_\_\_\_

List any other doctors you are seeing currently and describe what they are treating.

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List ALL medications, vitamins, and supplements (including homeopathic) you are taking. Please include dosages.

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Do you ever take medication *NOT* as prescribed? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

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How much do you weigh? \_\_\_\_\_ pounds                      How tall are you? \_\_\_\_\_ feet \_\_\_\_\_ inches

Do you have any allergies? \_\_\_\_\_ If yes, specify \_\_\_\_\_

**DAILY HABITS**

How many meals do you eat on a typical *weekday*? \_\_\_\_\_ How many meals do you eat on a typical *weekend* day? \_\_\_\_\_

About how many calories do you consume on a typical weekday? \_\_\_\_\_ Weekend day? \_\_\_\_\_

Do you participate in a regular exercise routine?            Yes            No            (Circle one)

If yes, please describe

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Do you currently use ....    If yes, on average, ...

Tobacco	Yes	No	Cigarettes per day?
Caffeine	Yes	No	Cups per day?
Alcohol	Yes	No	Drinks per day?
Recreational drugs	Yes	No	Daily usage?

How do you manage stress?

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Do you have problems sleeping? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

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## EMOTIONAL PROBLEMS

Briefly describe the problem or concern that brings you here today and when it began.

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Describe any significant changes or stressors in your life in the last year.

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Please check the items below that describe or relate to the concerns and/or stressors mentioned above:

Decreased appetite		Discouragement/hopelessness	
Increased appetite		Decreased energy/motivation	
Suicidal thoughts		Low self esteem	
Suicidal behavior		Body image disturbance	
Feeling worthless/guilty		Sexual concerns	
Feeling anxious/fearful		Divorce/custody	
Bereavement		Legal	
Anger		Marriage/Relationship (sig other, family, friends)	
Sadness		Personal growth	

If you have seen a counselor, psychologist, or psychiatrist in the past, please give their names, approximate dates seen, and what they treated.

Name	Approximate Dates Seen	Treated

Are you currently seeing another therapist? Yes No (Circle one)

If yes, please provide their name and contact info

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Have you ever had problems with alcohol or drug abuse?      Yes    No (Circle one)

Have you ever been in treatment for substance abuse?      Yes    No (Circle one)

If yes to either/both questions, please provide details (e.g., substance, dates, time sober, etc)

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How many times in the last 12 months have you had four or more (women)/five or more (men) standard drinks on one occasion? (Standard drink = 12 oz. beer, 5 oz. wine, 1.5 oz liquor)

\_\_\_\_\_ 0      \_\_\_\_\_ 1      \_\_\_\_\_ 2      \_\_\_\_\_ 3      \_\_\_\_\_ 4      \_\_\_\_\_ 5 or more

Have you ever experienced any of the following as a child or an adult? (Circle Yes or No for each item below)

Sexual Abuse      Yes    No    DK      Victim of Crime      Yes    No    DK

Emotional Abuse      Yes    No    DK      Suicidal Thoughts      Yes    No    DK

Physical Abuse      Yes    No    DK      Suicide Attempt      Yes    No    DK

Eating Disorder      Yes    No    DK

If yes to any item above, please describe

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If you experienced abuse as a child, what age(s)? \_\_\_\_\_ Was it reported to authorities? \_\_\_\_\_

If anyone in your family of origin (e.g., mother, father, siblings, grandparents, uncles, aunts, cousins) has experienced substance abuse, schizophrenia, bipolar disorder (i.e., manic-depression), depression, eating disorder, or other major emotional problems, please list the abuse/problem and your relationship to them.

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What are your treatment goals? \_\_\_\_\_

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**CONSENT FOR RELEASE OF INFORMATION**

I give consent for Dr. Monika Peterson and the healthcare providers listed below to exchange any and all information pertaining to my medical and mental health state and treatment to the extent such disclosure is necessary for coordination of treatment, case management, claims processing, quality assurance, and/or utilization review purposes.

I understand that I can revoke my consent at any time by submitting a written request to that effect, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after the date it is given.

**My signature below indicates that I have read, understand, and agree to the above.**

Signature of patient \_\_\_\_\_ Date \_\_\_\_\_

Print patient name \_\_\_\_\_

Signature of parent, guardian, or authorized representative (when required):

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
(Relationship to patient)

**I authorize Dr. Monika Peterson to contact and exchange information with:**

<b>Provider Name</b>	<b>Contact Info (Telephone Number/Address)</b>	<b>Date of consent</b>	<b>Patient (Guardian) Signature</b>

Specific information to be exchanged: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_