Erin M. Thomas, MA, LPC

Erin M Thomas Therapy, LLC. **1200 S. College Ave, Suite208**
(970) 672-5535 (office) **Fort Collins, CO 80524**

ADULT INTAKE FORM

Thank you for taking the time to complete this form. The information and history you provide to me will be helpful in planning services for you. Please answer each question carefully and ask about any question you don't understand. The information on this form is confidential and will not be released without your permission.

Today's Date: _____

How did you hear about me? Circle one:

☐ Family member ☐ Friend ☐ Internet ☐ Insurance ☐ Child Advocacy Center
☐ Other therapist ☐ Doctor ☐ Department of Human Services ☐ Attorney

Other: _____

Indentifying Information

Name: _____ Date of Birth: _____ Age: _____ Sex: M or F Race: _____ Religion: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Okay to leave a message? Y ☐ or N ☐
Cell Phone Number: _____ Okay to leave a message? Y ☐ or N ☐
Work Phone Number: _____ Okay to leave a message? Y ☐ or N ☐
Occupation: _____ Place of Employment: _____
Relationship Status: _____

Family Composition

Name	Age	Date of Birth	Relationship	How do they get along?

Medical History

Primary care provider: _____
Medications you are currently taking: _____
_____
Have you previously attended therapy? Y ☐ or N ☐
Who did you see? _____
Reason you were seen in therapy: _____
Type of therapy you received: _____
Was the therapy helpful? Circle one: Helpful ☐ Somewhat helpful ☐ Not helpful ☐
Have you experienced any of the following? Please circle and describe.
-chronic illness: _____
-surgeries: _____
-hospitalizations: _____
-high fevers: _____
-head injuries: _____
-seizures: _____
-eating problems: _____
-sleeping problems: _____
-encopresis/enuresis: _____
-problems with coordination: _____
-other: _____

Current Stressors

Please circle any of the stressors you have experienced over the last 12 months:

Death of a parent ☐	Divorce ☐	Death of a spouse ☐
Remarriage ☐	Death of a family member ☐	Death of a child ☐
Personal injury or illness ☐	Job loss ☐	Sexual abuse (self) ☐
Sexual abuse (family member) ☐	Change in family member's health ☐	Birth of a child ☐
Alcohol/drug addiction in family ☐	Change in financial status ☐	Vacation ☐
Change in living condition ☐	Change in residence ☐	Change of job ☐

Other: _____
_____
_____

Please describe why you are seeking therapy at this time: _____
_____
_____
_____

How long have you been experiencing these problems?_____
_____

What have you tried to help yourself so far? _____

_____

_____

Have you ever tried to hurt or kill yourself? Y ☐ or N ☐

If yes, please describe: _____

_____

_____

If yes, when did this occur? _____

Please circle all behaviors that apply to you:

☐ Addictive Behaviors	☐ Agitation	☐ Aggressive Behavior	☐ Anger and Rage
☐ Anorexia	☐ Anxiety	☐ Attachment Problems	☐ Body Tension
☐ Bulimia	☐ Chronic Fatigue	☐ Compulsive Behavior	☐ Conflict with peers
☐ Constipation	☐ Depression	☐ Despair	☐ Difficulty Sleeping
☐ Dissociative Episodes	☐ Early Trauma	☐ Emotional Expression	☐ Headaches/Migraine
☐ Emotional Overwhelm	☐ Fear and Anger	☐ Fybroidmyalgia	☐ Emotionally Reactive
☐ Hyper-Vigilance	☐ Impulsivity	☐ Irritability	☐ Irritable Bowel
☐ Lacking Boundaries	☐ Mental Calming	☐ Mood Swings	☐ Motivation
☐ Nightmares	☐ Night Terrors	☐ Obsessive Neg.Thoughts	☐ Obsessive Worry
☐ Panic Attacks	☐ Paranoia	☐ Perfectionism	☐ Phobias
☐ Physical Tension	☐ Poor Concentration	☐ Seizures	☐ Self-Esteem
☐ Self-Injurious Behavior	☐ Sexual Concerns	☐ Short-Term Memory	☐ Sleep Walking
☐ Stomachaches	☐ Suicidal Thoughts	☐ Trauma	☐ Verbal Expression
☐ Vertigo	☐ Withdrawn	☐ Working Memory	

Other:_____

Which of the above behaviors are the most concerning to you? _____

_____

Is there any other information that would be important for me to know about you?

_____

_____

_____

_____

_____

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____