Roze Therapy

Adult Intake

Name_____ D.O.B_____ Date_____

Full Address_____

Home Phone_____ Work_____ E-mail_____

Physical History

Are you now under a doctor's care? _____If yes, name of doctor_____

Reason for doctor's care_____

Are you taking any medication? _____If yes, what kind?_____

Reason for medication _____Last medical examination_____

Have you ever been hospitalized for a physical illness? _____

Describe_____

Have you ever been hospitalized for a mental illness? _____

Describe_____

Any recent major illnesses or surgeries?_____

Any recurrent or chronic conditions?_____

Do you smoke: _____Do you take drugs? _____If yes, what kind?_____

Do you drink? _____How much?_____

Any Previous Therapy/Counseling? _____

If yes, describe, when, where, how long, what for_____

Occupation: _____ How long?_____

Hobbies: _____

Family History:
Parents: Father alive? _____Where residing _____Relationship_____

Mother alive? _____Where residing _____Relationship_____

Marital Status _____#of marriages _____Spouse's name_____

Children:#1 M F Age_____ #2 M F Age_____ #3 M F Age_____#4 M F Age_____#5 M F Age_____

Family History of addiction? _____

Any step-parents? _____If yes, describe when and your relationship with them_____

Emotional Status

Did you have what you would consider to be childhood or other trauma? _____

Do you have any current or past experience with domestic violence? _____

Have you had any thoughts of suicide? _____ If so, when last did you have them _____

Do you have any thoughts now? _____

Present Situation

Please state why you decided to come for counseling/therapy

_____

_____

How long has this been a problem for you?
_____

Briefly state what you would like to work on in
therapy_____

_____

Emergency Contact Info

Name_____ Relationship _____

Phone number _____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.