



# WATERSHED

COUNSELING AND CONSULTING

3069 Broad Street, Suite 7 D, Chattanooga, TN 37408, v/m 423.556.0305

## Confidential Information – Adult Intake

(Please Print and use black ink)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
first middle or maiden last

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: Male  Female  Education \_\_\_\_\_

Home Address \_\_\_\_\_  
street city state zip

Cell/Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Work Phone \_\_\_\_\_ Employer \_\_\_\_\_ Years \_\_\_\_\_

Work Address \_\_\_\_\_  
street city state zip

Please circle any addresses, phone numbers or e-mails that you **DO NOT** want me using to reach you OR to leave you a message. I do not want to compromise your confidentiality or create an uncomfortable situation.

Marital Status \_\_\_\_\_ Date of present marriage \_\_\_\_\_ Date(s) of previous marriage(s) \_\_\_\_\_

Spouse's name \_\_\_\_\_ Age \_\_\_\_\_ Education \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Years \_\_\_\_\_

### Other Family Members Circle (M)ale or (F)emale.

Child(ren): _____ Age _____ M/F	Your Father _____ Age _____
_____ Age _____ M/F	Your Mother _____ Age _____
_____ Age _____ M/F	Brothers/Sisters: _____ Age _____ M/F
_____ Age _____ M/F	_____ Age _____ M/F
_____ Age _____ M/F	_____ Age _____ M/F
_____ Age _____ M/F	_____ Age _____ M/F
_____ Age _____ M/F	_____ Age _____ M/F

Former-Spouse \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: S / REM / Div Years \_\_\_\_\_

Former-Spouse \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: S / REM / Div Years \_\_\_\_\_

### Physician / Internist / Gynecologist / Psychiatrist / Etc. (Doctor(s) seen routinely)

[1] Name \_\_\_\_\_ Ph. ( ) \_\_\_\_\_ Years \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

[2] Name \_\_\_\_\_ Ph. ( ) \_\_\_\_\_ Years \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have any current or ongoing medical problems, symptoms, or significant hospitalizations? Please explain:

\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS:**

Taken as prescribed?

<u>Medication</u>	<u>Dosage</u>	<u>Yes</u>	<u>No</u>	<u>Doctor</u>	<u>Reason</u>	<u>How Long?</u>
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

Do you smoke or use tobacco?  Yes  No If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much per: day / week / month / year? \_\_\_\_\_ How long? \_\_\_\_\_

Do you use non-prescription drugs?  Yes  No If yes, what kinds? \_\_\_\_\_ How long? \_\_\_\_\_

Does your family have a history of substance dependence or abuse?  Yes  No If yes, substance? \_\_\_\_\_

Previous Mental Health Services:

<u>Provider</u>	<u>Location</u>	<u>Dates of Service</u>

Current or expected legal involvement?  Yes  No Current Order of Protection or Restraining Order?  Yes  No

If yes, please explain. \_\_\_\_\_

Referred by: \_\_\_\_\_ Friend / Doctor / Therapist / Agency / Church Phone: \_\_\_\_\_

May I have your permission to thank this person for their referral?  Yes  No Initials: \_\_\_\_\_

Emergency contact(s): \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Please provide your signature to indicate that I may contact them, if needed. (Your Signature): \_\_\_\_\_

Religious affiliation: \_\_\_\_\_ Frequency of involvement/activities \_\_\_\_\_

Current level of satisfaction with your friends and social support: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Circle level

List your leisure interests and activities:

What do you consider to be your strengths?  
\_\_\_\_\_

Briefly describe the concerns and reasons that brought you here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What you would like to achieve and/or see happen by coming here for care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_