DRCoughlin
Licensed Mental Health Counselor

1101 South Belcher Road Suite E
Largo, FL 33771
(727) 532-1997 Fax (727) 524-1332

ADULT INTAKE FORM

Name: ________________________________SSN: _____________________ Date: ___________

Home Address: ____

City: ____ Zip code: ______________________

Home Phone: _________________________ Work Phone: _______________________________

Cell Phone: ___________________________

Email: ____

Date of Birth: _________________________

Primary Care Physician:__________________________________Phone: ___________________

Address:____

City/State:____Zip Code:_________________

Person responsible for payment:___________________________Relationship:______________

Driver's license number:_____________________________________State:___________________

Address:____

City:____Zip Code:_________________

Phone: _______________________________

Number is household: ____________Would others be willing to come in?______ Yes ______ No

Have you been in therapy before? ____Yes ____ No

If yes, briefly provide details: ____

_____

Have you ever been hospitalized for mental disorders? _____Yes _____ No

If yes, provide details: _____

_____

Why are you seeking therapy at this time? _____

_____

What are your goals for therapy? _____

_____

Are you concerned about your sexual activity? ____ Yes ____ No

If so, why? _____

_____

Do you have any concerns about your eating patterns? ____ Yes ____ No

If so, what are they? _____

_____

Do you drink caffeinated beverages? ____ Yes ____ No

If yes, quantity: _____

Describe your usual diet, including beverages:

- Breakfast: _____
  _____
- Lunch: _____
  _____
- Dinner: _____
  _____
- Snacks: _____
  _____