LINDA FOLTZ, PH.D.
LICENSED PSYCHOLOGIST

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ADULT INTAKE FORM

This information and all communications with your therapist, will be kept confidential to the full extent of Georgia Law.

CLIENT INFORMATION

Name ____ Today's Date: ________________

Home Address ____

City, State & Zip ____

Social Security Number____________________________ Date of Birth: ______________________

Employer _______________________________ Occupation _____________________ Hrs/wk _____

Employer's Address ____

Can you be contacted at work by phone? Yes No Work phone: (___)____________ ext: ________

Age _____ Sex: F M Race _______ Cell Phone: (___)__________ Home: (_____)

Denomination _________________ Church: ______________________________ Active? Yes No

In case of Emergency, notify: _________________________ Phone #: _________________________

RELATIONSHIP TO YOU: ___________________________________

Presently living with:		Marital Status:		Highest Education Completed:	
Parents	________	Single	________	Elementary School	________
Spouse	________	Married	________ (yrs.)	High School	________
Roommate	________	Separated	________	College	________
Alone	________	Divorced	________ (yrs.)	Graduate School	________
Other:	___________	Widowed	________	Professional School	________
		Other:	_______________	Other (specify):	____________

SPOUSE INFORMATION

Spouse's Name ____

Address (if different from client) ____________________________________Phone: ____________________

Employer _______________________________ Occupation _____________________ Hrs/wk _____

Employer's Address ____

FAMILY MEMBERS

Relationship	Name	Age	School Grade last completed	Occupation if out of school	Check if Living with you
Spouse:					
Father:					
Mother:					
Children:					

Other: ____

Describe any physical problems you have that require medication or physical care: ______________

____

Medication(s) currently using: ____

Are you currently receiving medical treatment? Yes No Physician: ____________________

Previous Counseling/Therapy? Yes No If yes, when? __________________________

Where and with whom? (Please list all) ____________________________________

____

____

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place **2** checks by those items which are most important. (You may add written comments after areas checked.)

1. _____ Anger/Temper
2. _____ Depression
3. _____ Education
4. _____ Family Problems
5. _____ Fearfulness
6. _____ Marital Problems
7. _____ Physical Problems
8. _____ Problems with Social Relationships
9. _____ Problems with Children
10. _____ Religious/Spiritual Concerns
11. _____ Sexual Concerns
12. _____ Thoughts of suicide
13. _____ Trouble making decisions
14. _____ Unhappy most of the time
15. _____ Use of Alcohol
16. _____ Use of Drugs
17. _____ Work
18. _____ Worry
19. _____ Other (specify):

Briefly describe the main problem which prompted you to seek counseling at this time:

____

____

____

____

____

Is there anything else which you believe might be important for Dr. Foltz to know at this time?

____

____

____

I learned about Dr. Foltz from: ______________________________________

Is it alright with you if we thank them for the referral? Yes No

Signature_________________________________ Date ______________