Jean Wolfe Powers, M.A., L.M.F.T.
Licensed Marriage and Family Therapist
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Confidential

Adult Intake

Welcome to my psychotherapy practice. Please complete this form to the best of your ability. Some items are required for you to be seen. Please, *Print* legibly.

Today's date: _____

Name: _____

Circle Title: Mrs. Ms. Mr. Dr.

Age: _____ **Birth date**: _____

Circle Marital Status: Single Married Civil Union Separated Divorced Widowed

Contact Information:

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Phone: Home: _____ Cell: _____

Office: _____ Fax: _____

Education and Employment

Circle Highest Degree: HS Tech Certificate Associates BA/BS MA/MS Doctorate

Field of Employment/Job Title: _____

Employer: _____

Employer's Address: _____

Family

Name of Spouse /Significant Other: _____

Age: _____ Years together: _____

Children
Please list names Age_____ Living at Home _____

_____ _____

_____ _____

Your History

Place of Birth: _____

Where did you grow up? _____

Who raised you? _____

List your siblings Ages _____

_____ _____

_____ _____

Describe any mental illness in your family. (Example: My father and son suffer with depression)

List past mental health care you have had.

Professional's Name _____

Title/Degree _____Dates of service _____

List any medical problems you have, and your medications.

If you have now, or have a history of any of the following, circle the item(s).

Alcoholism Eating Disorder Illicit Drug Use Prescription Drug Addiction

Prescription Drug Abuse Victim of Childhood Abuse Victim of Abuse as an Adult

Victim of Rape Abuser of a Child Abuser of an Adult Jail/Prison Time

Smoking Caffeine Abuse/Addiction Panic Disorder Head Injury

Suicidal Behavior/Thinking Homicidal Behavior/Thinking CVA/Stroke

Learning Difficulty/Disorder Sleep Disorder Self-Inflicted Injury

In a sentence or two, what is your reason for seeking psychological care?

Agreements

I understand that Jean Wolfe Powers is an LMFT and an International Certified Life Coach and I agree to being treated either in her office or by virtual therapy via video or phone. I agree to pay Ms. Powers her current fee at the time of each session. **I understand that I am responsible for payment in full for any session that I do not attend/do not cancel with a minimum of 48 hours notice.** I may cancel a session via telephone or in person.

Patient/Client Signature:_____Date:_____

I understand that electronic communications are not always considered secure, thus Ms. Powers cannot protect information passed via electronic methods.

Patient/Client Signature:_____Date:_____

How did you find me?

Friend's Recommendation Insurance Plan Physician Recommendation

Family Member Internet Other