

Jean Wolfe Powers, M.A., L.M.F.T.
Licensed Marriage and Family Therapist
California License # MFC25278
Virginia License # 0717001090

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 telephone. I agree to pay Ms. Powers her current fee of _____ 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 24 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. Telephone messages left for Ms. Powers at the office number will be returned as soon as she is able. If a true psychological emergency exists, I should not wait for a return call/response. Instead, I should try again, call my physician, call a crisis center and/or dial 911 for assistance.

Patient/Client Signature: _____ Date: _____

How did you find me?

Friend's Recommendation Insurance Plan Physician Recommendation
Family Member Internet Phone Book Other