Wellness Associates, LLC

1271 Ethereal Circle | Colorado Springs, CO 80904
719.323.8909 | Info@WellnessAssociatesllc.org

Adult Intake Form

Full Name: _____ Date of Birth: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone: _____Voicemail (yes/no) Texting - appointment schedule/reminder only (yes/no)
Alternate Phone: _____ Voicemail (yes/no) Texting - appointment schedule/reminder only (yes/no)
Email: _____ Employer: _____
Emergency Contact: _____ Relationship: _____
Preferred Phone: _____Voicemail (yes/no) Alternate Phone: _____ Voicemail (yes/no)
Living Arrangement: ❑ alone ❑ with roommate(s) ❑ with spouse/partner ❑ with children ❑ with parents
Status: ❑ Married ❑ Divorced ❑ Remarried ❑ Never Married ❑ Other (please specify) _____

What would you like to accomplish in counseling? Please list your goals:
1._____
2._____
3._____

How do you hope therapy might change things for you? _____
Do you have any concerns regarding therapy? _____

Current Personal Concerns (Please circle all that apply):
Stress, Nervousness, Depression/Sadness, Angry, Aggressiveness Towards Others, Academic Problems, Shyness, Eating Difficulties, Recent Loss, Health Concerns, Self-Control, Drug/Alcohol Use, Head/Stomach Aches, Loneliness, Feeling Inferior, Parenting Issues, Fears, Legal Problems, Sleep Difficulties, Sexual Assault, Fatigue, Difficulty with Friends, Attention/Memory, Nightmares, Career/Employment Issues, Sexual Problems, Loss of Interest, Troubling Thoughts, Suicidal Thoughts, Difficulty Relaxing, Separation, Identity Issues, Concentration, Other (Please Explain): _____
I use alcohol/drugs ____ times per week. Has your alcohol/drug use ever caused problems? _____

Family History
Previous Counseling or Inpatient Mental Health Treatment: _____
Suicide /Attempted Suicide: _____
Depression /Anxiety: _____
Physical, Emotional, Sexual Abuse or Neglect: _____
Drug and/or Alcohol Abuse: _____
Serious Illnesses / Injuries: _____
Legal Difficulties: _____
Other (Please Explain): _____
Major changes during the past 5 years: _____

How did you hear about Wellness Associates? _____ Did you visit our website? (yes /no)
Signature: _____ Date: _____
Therapist Signature: _____ Date: _____