BrightWay Counseling and Wellness

Intake Survey- Adult

Name:________________________________Age:_______________

Date of Birth:________________________

Address:____

____

Phone: ______________________ Cell Phone______________________

Email _______________________________________:

Place of employment /occupation: ____

Doctor: ______________________________Doctor's Phone Number:_______________________

Emergency Contact:___________________________ Phone Number:_____________________

***Single* ______ *Married*_____ *Separated*_____ *Divorced*_______**

Children:

1. ______________________________ m / f Age:________
2. _______________________________ m / f Age:________
3. _______________________________ m / f Age:________
4. ________________________________ m / f Age:_________

Please list everyone that currently lives in your home:

____

____

Medical

Are you currently receiving any medical or mental/health treatment?

Yes No

If so where or by whom? :____

List all areas/conditions being treated: ____-

List any prescribed medications you are currently taking:

Name Dosage

List any over the counter medications or supplements that you currently take:

Have you ever been diagnosed with a learning disorder or mental/emotional disorder? **Yes/ No**
If so, please specify:

Date: Diagnosis:

Are there any medical or mental health conditions that occur in your family? **Yes** **No**
If so, list all and the relevant family member/relation to client.

Relative/family member | Condition | Age of onset (about)

Who may I thank for referring you to my practice?

What do you hope for counseling to accomplish for you or your family?

Please list your immediate concerns in order of importance:
1.

2.

3.

4.

5.

Please include anything else you feel is important here regarding you or your family:

Signature____________________________ Date:______________________