Audrey Hockman, MA, MPH, LMHC
Advanced Women's Health
2102 North Pearl Street, Suite 405
Tacoma, WA 98406
(253) 752-8822

Adult Intake

Welcome! This form is the first step in identifying your current concerns and helping me understand how to help you. You don't need to give too much detail as we will go over this form more thoroughly during your first session.

Please bring this form with you to your first session.

General Information

Date_____

Name_____

Birthdate_____ Address_____

City_____ ZIP_____

Home Phone _____ Mobile Phone_____

Preferred number/email for me to contact you_____

How were you referred to me? _____

Medical History

Physician's name and phone number:
_____

Major health conditions (current or past):
_____
_____
_____

List any medications, supplements, vitamins, herbs that you take: (please use back of sheet if needed)
Name: For what condition: Prescribed by:
_____
_____
_____
_____

Please describe any current concerns with alcohol or drug use in yourself or in your family:_____
_____

Audrey Hockman, MA, MPH, LMHC

Advanced Women's Health
2102 North Pearl Street, Suite 405
Tacoma, WA 98406
(253) 752-8822

Have you been in therapy before? Y/N
If yes, please provide previous therapists' names and dates of therapy:

_____
_____

Have you found therapy to be helpful in the past? What worked and what didn't?

_____
_____

Please describe your current nutrition/eating habits, water and caffeine intake:

_____
_____
_____

Please describe your sleep habits:

_____
_____

Please describe your exercise habits:

_____
_____

Have you ever attempted suicide? Y/N If yes, at what age?

_____

Considered suicide? _____

Work and Education

Please briefly tell me about your employment background, including dates.

_____
_____
_____
_____

Please briefly tell me about your educational background, including dates.

_____
_____
_____
_____

Relationships

Relationship Status:
Single _____ Married_____ (Date) _____ Living with a partner_____ (Date) _____
Separated____ (Date) _____Divorced___ (Date) _____Widowed___ (Date) _____

Audrey Hockman, MA, MPH, LMHC

Advanced Women's Health
2102 North Pearl Street, Suite 405
Tacoma, WA 98406
(253) 752-8822

If married or in a committed relationship:
Partner: _____ Birthdate:_____
Occupation: _____Employer/School: _____

If you have children:

Name	Age	Living at home with you?

Please list anyone else living in the household

_____
_____

Do you have a good support system (people you can turn to with problems, to have fun, people who enrich your life)?

_____
_____

Family of Origin Background

As a child or teen, did you experience:
__separation from one or more parents? __Out of home placement? __Depression of primary caregiver?
__Addiction in a primary caregiver? __death or chronic illness of a family member? __abuse? __neglect?
__chronic pain or illness? __disruption in bonding? __witness to a death or traumatic event?
__sexual abuse/assault?

What three words would you use to describe your relationship with your:

Childhood Female Caregiver:

Childhood Male Caregiver:

Sister(s):

Brother (s):

Adopted/Step_____:

Adopted/Step_____:

Audrey Hockman, MA, MPH, LMHC
Advanced Women's Health
2102 North Pearl Street, Suite 405
Tacoma, WA 98406
(253) 752-8822

Were you adopted or in foster care? Y/N_____

Were you ever out of your primary caregivers' care and/or home for any reason?
_____
_____
_____

Other significant relationships that have impacted your life: (grandparent, neighbor, aunt, teacher, etc.)
_____
_____
_____

Any known mental health or addiction issues in your family of origin? If so, please explain.
_____
_____
_____

Self-Knowledge

When were you happiest?
_____
_____

What do you do with your anger?
_____
_____

What do you like most about yourself?
_____
_____

What do you do for fun and relaxation?
_____
_____

How do you best express yourself?
verbally___ writing or poetry___ music___ drama___ painting/drawing/sculpting___ physical movement or dance___ other_____

What brings you to counseling?
_____
_____
_____
_____
_____

Audrey Hockman, MA, MPH, LMHC

Advanced Women's Health
2102 North Pearl Street, Suite 405
Tacoma, WA 98406
(253) 752-8822

What do you hope to achieve in therapy? Goals and Expectations?

_____
_____
_____
_____
_____
_____

What do you see as your greatest strengths that will help you attain your therapy goals?

_____
_____
_____
_____
_____
_____

What weaknesses may hold you back?

_____
_____
_____
_____
_____
_____

Anything else that would be helpful for me to know?

_____
_____
_____
_____
_____
_____

_____ _____

Signature Date

.

Looking forward to starting this journey with you!