



Tiffany Adams, LCSW  
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**Intake Form**

**Generalized Information:**

<b>Name:</b>			
<b>SS #</b>	<b>Age</b>	<b>DOB:</b>	
<b>Address:</b>			
<b>Telephone number(s)</b>	<b>Home:</b>	<b>Work:</b>	<b>Cell:</b>
<b>Can I leave a message at this number?</b>	YES/ NO	YES/ NO	YES/ NO
<b>Preferred way to be contacted (circle choice):</b>	Home	Work	Cell
<b>May you be contacted by Email? YES / NO</b>		<b>Email:</b>	

*Please, include spouse/ partner information if seeking couples/family therapy:*

<b>Client:</b>			
<b>SS #</b>	<b>Age</b>	<b>DOB:</b>	
<b>Address:</b>			
<b>Telephone number(s)</b>	<b>Home</b>	<b>Work</b>	<b>Cell</b>
<b>Can I leave a message at this number?</b>	YES/ NO	YES/ NO	YES/ NO
<b>Preferred way to be contacted (circle choice):</b>	Home	Work	Cell
<b>May you be contacted by Email? Yes / NO</b>		<b>Email:</b>	

*Please include information if treatment is for minor child:*

<b>Parent/Legal guardian name:</b>		
<b>Who does child live with?</b>		
<b>Grade:</b>	<b>School</b>	<b>Teacher</b>

<b>In case of emergency, who may I contact on your behalf?</b>	<b>Name:</b>
<b>Phone number:</b>	<b>Relationship:</b>





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<b>Marital/ Partner/ Relationship Status (circle all that apply):</b>			
Single	Married	Divorced	Separated
Widowed	Remarried	Long-term relationship	Cohabiting
<b>Current partner's name</b>		<b>Partner's occupation:</b>	<b>Length of relationship:</b>
<b>How satisfied are you with your current relationship (on a scale from 1-10)?</b> (very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)			

<b>What is your occupation?</b>	<b>Employer:</b>
<b>Do you enjoy your occupation? YES / NO</b>	<b>Average hour worked per/week</b>

<b>Highest level of education:</b>	High school	Some college	College degree	Graduate School	Other
<b>If you received a college/graduate degree, what was your degree in?</b>					
<b>If you are currently in school, what are you studying?</b>					

<b>How would you describe your spiritual or religious beliefs?</b>
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<b>Have you ever received or given abuse? YES/ NO</b>	<b>If yes please circle type:</b> Physical Emotional Sexual Neglect Other
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<b>Do you have a primary care physician? YES / NO</b>	<b>Physicians name:</b>
<b>Are you under the care of a psychiatrist? YES/ NO</b>	<b>Psychiatrist name:</b>
<b>If minor does child have a pediatrician? YES/ NO</b>	<b>Pediatricians name:</b>

<b>Are under the care of specialist? YES/ NO</b>					
<b>If yes, please circle specialist(s) which provide you care:</b>					
Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility Specialist	Nephrologist
Neurologist	Nutritionist	Occupational therapist	Oncologist/ Hematologist	Orthopedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:





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<b>Do you drink alcoholic beverages?</b> YES/ NO	<b>If yes how many alcoholic beverages do you drink</b> _____ weekly _____ daily
<b>Do you think you have a drinking problem?</b> YES/ NO	<b>Does anyone else think you have a drinking problem?</b> YES/ NO

<b>Do you smoke?</b> YES/ NO	<b>If yes how many cigarettes/packs a day does you smoke?</b> _____ cig. _____ packs a day
<b>If yes when did you start smoking?</b> _____ age	<b>Have you ever tried to quit?</b> YES/ NO

<b>Have you in the past or currently used abused, experimented with illegal drugs?</b> YES/ NO	<b>If yes, briefly describe:</b>
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<b>Have you ever attempted/ seriously contemplated suicide?</b> YES/ NO
<b>If yes, describe briefly and indicate dates:</b>

<b>Have you ever had a psychiatric hospitalization?</b> YES/ NO
<b>If yes describe briefly and indicate dates</b>

**Therapy Experiences and Expectations:**

<b>Are you <i>currently</i> seeing another therapist?</b> YES / NO			
<b>If yes, who are you seeing?</b>			
<b>Have you ever been in therapy in the past</b> YES/ NO			
<b>If yes, please fill out the following on your previous counseling experience(s)</b>			
<b>Therapist</b>	<b>Location</b>	<b>Dates</b>	<b>Reason</b>

<b>Briefly describe your reason(s) for seeking help at this time:</b>
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**What goals do you wish to accomplish during the therapy process?**

**Is there anything else you would think would be important for me to know about you or your family?**

**Who referred you? Did you find me on the web? If so, which site did you visit?**

**If a person referred you, may I contact him or her to thank them: YES/ NO**

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