Aden Burka Wright, LCSW
7821 Maple St., New Orleans, LA 70118
(504) 303-4034
www.adenburkawright.com

Adult Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name:

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age:

_____

Significant relationships outside of your family:

_____

Who lives in your household?

_____

Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( )

Cell/Other Phone: ( )

May we leave a message? □ Yes □ No
May we send you text messages? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

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Emergency Contact:

Name:_____Relationship:_____

Address:_____

_____

Phone Number:_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner and dates:

_____

_____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list:

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns

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Do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Have you experienced any significant life changes or stressful events recently? If yes, please explain.

Are you under the care of a Primary Care Physician? □ Yes □ No

Name of PCP:_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	

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Schizophrenia yes/no

Suicide Attempts yes/no

ADDITIONAL INFORMATION:

Referred By:_____

Are you currently employed? □ No □ Yes

If yes, what is your occupation?

What would you like to accomplish out of your time in therapy?

Is there anything else you would like me to know?