

**Dr. Vicki Ehrlich, PsyD**  
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### Adult Intake Form

#### Contact information

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip code) \_\_\_\_\_

Home number: \_\_\_\_\_ Can I leave voicemail:  Yes  No

Mobile number: \_\_\_\_\_ Can I leave voicemail:  Yes  No

Email address: \_\_\_\_\_

Preferred method of communication: \_\_\_\_\_ Referred by: \_\_\_\_\_

#### Personal Information

Dob: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship Status:  married  single  domestic partnership  separated  divorced  
 widowed  Other: \_\_\_\_\_

If married/partnered:

Name of partner/spouse: \_\_\_\_\_ How long have you been together: \_\_\_\_\_

Do you have children:  Yes  No Please list names/ages: \_\_\_\_\_

#### Presenting Problem

Reason for coming: \_\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip code) \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Medical History

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Have you had prior psychotherapy?  Yes  No

- If yes, with who: \_\_\_\_\_ For how long: \_\_\_\_\_
- For what concerns: \_\_\_\_\_

Have you ever been prescribed any psychiatric medications?  Yes  No

- If yes what medications: \_\_\_\_\_

List any medical problems: \_\_\_\_\_

Please list current medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

How often do you drink alcohol and how much do you typically drink? \_\_\_\_\_

Do you smoke cigarettes (if yes how often)? \_\_\_\_\_

Do you have any concerns about your use of alcohol or drugs?  Yes  No

- If yes please describe: \_\_\_\_\_

## Family Health History

Family history of mental health: \_\_\_\_\_

Family history of medical concerns: \_\_\_\_\_