Audra York Therapy, LLC
Audra York, LPC, MFT
4325 Laurel Street #230A Phone: (907) 952-8532
Anchorage, AK 99508

Adult Intake Questionnaire

Date:________________________

Last Name:______________________________ First Name:_________________ MI:________

Nickname:_______________________________

Date of Birth:____________________________ SS #:________________________________

Gender: Male Female

Referred By:_______________________________________

Ethnic/Cultural Origins:____

Allergies:____

Occupation:____

Home Address:____

City:___________________________ State:_____________ Zip Code:________________

Mailing Address (if different from home):____

City:___________________________ State:_____________ Zip Code:________________

Home Phone:_________________________ Cell Phone:_______________________ Carrier:___________

Work Phone:_________________________ Other:________________________________

Email Address:____

Emergency Contact:___________________________________ Ph:_____________________

Relationship:_____________________________

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Insurance Information

Primary Insurance:____

Insurance Phone:____

Insurance ID Number:_______________________________________

Insurance Group Number:____________________________________

Effective Date:______________________

Client's relationship to Insured:________________________________

Insured Name- Last:_____________________________, First:___________________________, MI:____

Insured Street Address:____

Insured City, State, Zip Code:____

Insured Phone Number:_________________________________

Insured Date of Birth:____________________________

Insured's Gender: Female Male

Insured's Employer:____

Secondary Insurance:____

Secondary Authorization Number:______________________________

Insured Name- Last:_____________________________, First:___________________________, MI:____

Client's relationship to Insured:________________________________

Insured Date of Birth:____________________________

Insurance ID Number:_______________________________________

Insurance Group Number:____________________________________

Effective Date:______________________

Insured's Employer:____

Insured Street Address:____

Insured City, State, Zip Code:____

Insured Phone Number:_________________________________

Insured's Gender: Female Male

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Who currently lives with you? (use additional paper if needed)

Names Date of Birth Relationship

____

____

____

____

____

____

Do you have a regular medical provider? Yes No

If yes, who do you see? ____

Date of last physical exam:_____________________

Any medical concerns or disabilities? Yes No

If yes, please describe: ____

____

Medications currently taking: ____

____

Have you had previous counseling, including residential treatment? Yes No

If yes, when/where:____

Do you have a history of self-harm or suicide? Yes No

If yes, when was the last incident? ____

Is there a family history of self-harm or suicide? Yes No

Is there a family history of mental illness or developmental delays? Yes No

If yes, please list relationships to you and illness and/or delays:

____

____

Is there a family history of substance or alcohol use/abuse? Yes No

If yes, please describe: ____

____

Does your partner ever make you feel uncomfortable, unsafe, or isolated? Yes No

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Please list any possible traumas (e.g. abuse, domestic violence, car accidents, grief and loss, etc.):

____

____

____

____

____

Therapeutic Services

Briefly describe the reason for seeking therapeutic services:

____

____

What are you hoping to gain from therapy?

____

____

____

What strengths do you have?

____

____

Are you interested in medication? Yes No

Any other comments or concerns? ____

____

____