Audra York, MS, LPC-S, RPT-S
Audra York Therapy, LLC
4141 B Street **Ph: (907) 952-8532**
Suite 301 **Fax: (907) 561-0225**
Anchorage, AK 99503 **www.audrayorktherapy.com**

Adult Intake Questionnaire

Date:________________________

(Legal) Last Name:___________________________ First Name:________________________ MI:________

(Legal) Gender: Male Female

Date of Birth:____________________________ Age:___________________

Preferred Name:_________________________________ Preferred Gender:_______________________

Preferred Pronouns:_________________________________

Allergies:____

Ethnic/Cultural Origins:_______________________________

Home Address:____

City:________________________________ State:_____________ Zip Code:________________

Mailing Address (if different from home):____

City:________________________________ State:_____________ Zip Code:____________________

Home Phone:_________________________ Cell Phone:_______________________

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 (Legal) Gender: Female Male

Insured's Employer:____

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:______________________

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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, please describe, including 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

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

____

____

____

____

____

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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? ____

____

____