## DOWNTOWN COUNSELING CENTER

155 S. Hanover St., Carlisle, PA 17013 PH: (717) 386-5971 F: (717) 386-5635 www.dcccarlisle.com

## ADULT INTAKE INFORMATION FORM

Please complete this form as best as you can and submit/send to <a href="main@dcccarlisle.com">main@dcccarlisle.com</a> prior to your

	and if not complete pr	rior to your sched	e appointment. Please know this form a luled intake appointment, the
	Part 1 – ID	ENTIFYING DATA	A
Name (Last, First, MI)		Birth Date:	Today's Date
Address:		•	
Home Phone:		Work Phone:	
Cell phone:		E-mail address:	
Gender: Male: Female:	Other: [ (please	specify):	
	Part 2 – PRES	SENTING PROBLI	EM
What is (are) your reason(s) for co	oming in today?		
How long have you been experien			
Have you had difficulties like this	before?  Yes  No (If ye	es, please explain)	
Are you having any self-destructive	ve or suicidal thoughts? 🗌 Y	es 🗌 No (If yes, pleas	ise explain)
T' 1'		SYCHIATRIC HIS	
List any previous psychiatric or su Reason	Location Location	ounseling or hospitaliz  Dat	
Reason	Location	Dat	Diagnosis (II Known)