



560 N. Exposition
Wichita, KS 67203
(316) 264-8317
Fax (316) 264-0347

Adult Intake Form

NAME: _____
First name Middle Initial Last Name Maiden Name

DOB: _____ **AGE:** _____ **SS NUMBER:** _____ **GENDER:** MALE FEMALE

ADDRESS: _____ **APT.#:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

PHONE NUMBER: _____
Home Cell Work

MARITAL STATUS: SINGLE MARRIED

RACE/ETHNICITY:
 African American/Black Chinese Hawaiian Caucasian/White Japanese Native American Vietnamese Hispanic Biracial Other

Others residing in the household: _____

Are there any immediate family members in the military? _____ **If so, have they served in combat?** _____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT? _____

IS TREATMENT COURT ORDERED? Yes No

WHO REFERRED YOU TO OUR AGENCY: _____

EMPLOYMENT INFORMATION: Full-time Student Part-time Student Employed N/A

Name of Employer: _____ Job Title: _____

Name of College/University: _____

FINANCIAL: Does financial stress relate to why you are seeking services? Yes No

If yes, please explain: _____

LEGAL HISTORY: Have you even been charged with a crime? Yes No Are you currently on probation? Yes No

If yes, please explain: _____

LIST HOBBIES OR RECREATIONAL INTERESTS: _____

FAMILY, CULTURE AND RELIGION: Describe any cultural and/or religious connections. _____

BEREAVEMENT AND GRIEF: Have you experienced grief or loss? If so, please describe how you are supported socially, spiritually and culturally. _____

PRIMARY CARE PHYSICIAN (PCP):

NAME: _____ **PHONE:** _____

ADDRESS: _____