Blissful Path Therapy

Follow your bliss

ADULT INTAKE EVALUATION

Name: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Can we leave a message if no one answers? OYes ONo Can we text to confirm? OYes ONo

Email: _____

Date of Birth: _____ Social Security #: _____

Referred by: _____

Emergency Contact: _____ Phone: _____

FAMILY

Mother living? OYes ONo Father living? OYes ONo

Describe your relationship with your parents: _____

_____

EDUCATION: _____

MARRIAGE

Marital Status: **S M D W** # of Marriages: _____

Spouse (ex-spouse)'s name: _____ How long? _____

Describe your relationship with your in-laws: _____

_____

Names and ages of your children:

_____ _____

_____ _____

_____ _____

HEALTH

Indicate if any of the following apply or have applied in the last six (6) months:

☐Loss of appetite ☐Unkempt appearance ☐Withdrawn ☐Sleeplessness ☐"Blahs" ☐Loss of sex drive

Blissful Path Therapy Services, LLC * Karie A Bliss, M.Ed., LMHC * 561-849-4071
5700 Lake Worth Road, Suite 110
Lake Worth, Florida 33463
www.blissfulpaththerapy.com
info@blissfulpaththerapy.com (email)

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Health: OVery Good OGood OAverage OPoor
Have you had a physical in the last year? OYes ONo Do you have any food/drug allergies? OYes ONo
Are you currently under a psychiatrist/doctor's care? OYes ONo
If yes, please describe: _____

_____

Psychiatrist/doctor's name: _____ Phone: _____
Are you currently taking medication? OYes ONo Type, dosage, usage: _____

_____

_____

Past or current history of (check all that apply):

☐AIDS	☐Chronic fatigue	☐HIV	☐Persistent flu-like	☐Thyroid problems
☐Anemia	☐Chronic pain	☐Hypertension	symptoms	☐Tuberculosis
☐Asthma	☐Diabetes	☐Liver damage	☐Seizures	☐Urinary tract infection
☐Cancer	☐Eating disorder	☐Migraines	☐STD	
☐Cardiac problems	☐Hepatitis		☐Stroke	

Do you use drugs? OYes ONo Drug(s) of choice: _____
Do you drink alcoholic beverages? ONever OOccasionally ORegularly
Drink(s) of choice: _____ Times per week: _____

EMPLOYMENT
Types and length of employment:

1. _____
2. _____

Current Employer: _____

RELIGION
Denomination: _____Participation: _____

PERSONAL
What is troubling you and with whom have you discussed it? _____

_____

_____

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What books, websites, workshops, seminars, etc. have you studied that deal with the reason you are seeking therapy? _____

_____

Check any you have experienced in the last six (6) months:

☐Adult child of Alcoholic	☐Change in lifestyle	☐Fear	☐Impotence	☐Sex
☐Anger	☐Children	☐Envy (Jealousy)	☐Loneliness	☐Spouse Abuse
☐Anxiety	☐Depression	☐Guilt	☐Motherhood	☐Suicidal thoughts
☐Assurance of Salvation	☐Dishonesty	☐Health issues	☐Psychotic episodes	☐Unforgiveness
☐ADD/ADHD	☐Eating Disorder	☐Homicidal thoughts	☐Rebellion	☐Violence/Rage
☐Bitterness	☐Fatherhood	☐Homosexuality	☐Recent Death	☐ _____

Do you live within your financial means? OYes ONo

Have you ever sought counseling or psychiatric help? OYes ONo
If yes, from whom and what counsel did you receive? _____

_____

I give my consent for services with Blissful Path Therapy Services, LLC and associated professional staff to include evaluation, psychotherapy, testing (if indicated), and involvement in the treatment planning process.

Signed _____ Date _____

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