

Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D.  
3 Hospital Drive, Suite 308  
Lewisburg, PA 17837

**ADULT INTAKE FORM**

First name: \_\_\_\_\_ MI \_\_\_\_\_ Last name: \_\_\_\_\_

Birthday dd/mm/yy: \_\_\_\_\_ Social Security number: \_\_\_\_\_ Gender: M F

Marital Status: Single Separated Divorced Widowed Today's date: \_\_\_\_\_

If married or separated, list spouse's name: \_\_\_\_\_

Home address \_\_\_\_\_ Home phone: \_\_\_\_\_ Ok to call? Y N  
\_\_\_\_\_ Work phone: \_\_\_\_\_ Ok to call? Y N  
\_\_\_\_\_ Cell phone: \_\_\_\_\_ Ok to call? Y N

Emergency contact \_\_\_\_\_ Emergency number/s \_\_\_\_\_  
Relationship of contact \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone # of Physician \_\_\_\_\_

**CONSENT TO TREATMENT**

I hereby request therapeutic services from Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D. I acknowledge and understand that no guarantee or assurance has been made as to the outcome/results that may be obtained from these services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please describe the concerns that brought you into counseling.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What behavioral goals do you have for yourself, your relationship or your family?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Have you received any counseling or medical treatment for behavioral problems or emotional issues in the past? If so, with whom? What were you treated for? Was it helpful?**

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**Are you in treatment for any physical illnesses or injuries at this time? If so, please describe.**

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**Do you take any medications at this time? If so, please list the medications, what each medication is meant to treat, and whether the medication seems to be helpful or not.**\_\_\_\_\_

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**Please list significant events in your medical history, such as prenatal problems, birth trauma, past surgeries, serious accidents, head injuries, significant illnesses, etc.**\_\_\_\_\_

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**Who, if anyone, lives with you? Please describe their relationship to you.**\_\_\_\_\_

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**If you have children or other significant others who do not reside with you, please list them here and describe their role in your life:** \_\_\_\_\_

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**Please also complete the Adult Symptom Screening Form. Thank you for your patience!**