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CLIENT INTAKE FORM

Confidential **Date:** _____

Basic Information:

SS#: XXXX-XX-_____ Date of Birth: ___/___/___

Client Name: _____ Age: _____

Address: _____ Ethnicity: _____

City: _____ State: _____ Zip: _____ Gender: _____

Home ☎ _____ Work ☎ _____ Cell ☎ _____

Circle which number is best to leave messages that might contain sensitive/private health information.

Email address: _____

Type of Counseling Sought: (circle) Individual Couples Family Group Info/Referral

Household Information:

(Circle) Single Co-habitating Married Separated Divorced Widowed

Partner's Name: _____ Partner's Age: _____

List all of the people living in your household *(besides you and your partner)* : If necessary, attach additional sheets

Name: _____ Age: _____ Relationship to You: _____

Name: _____ Age: _____ Relationship to You: _____

Name: _____ Age: _____ Relationship to You: _____

Name: _____ Age: _____ Relationship to You: _____

List name(s) and age(s) of *your* children not living with you: _____

Employment Information:

(Circle) Employed Unemployed Retired Student Studying: _____

Employer: _____ Occupation: _____

Full-Time ☐ Part-Time ☐ Approximate # of hours a week: _____

Name of Person(s) to Call in Case of An Emergency:

Please note: It may be necessary to break confidentiality when contacting your emergency numbers (or emergency personnel - i.e. police, ambulance, etc.) as required by law if you are posing a danger to yourself or others or are experiencing serious impairment.

Name: _____ ☎ _____ Relationship to You: _____

Name: _____ ☎ _____ Relationship to You: _____

Referral Source:

I was referred by: _____ Relationship to You: _____

Reason for referral: _____

Continued on other side.....

Health Information:

Overall Rating: (circle) Excellent Good Average Poor Very Poor

Are you currently under a **physician's** care? Yes ___ No ___

If yes, explain: _____

Physician's Name: _____ Phone Number: _____

Are you currently taking medication(s)? *(attach more sheets if necessary)* Yes ___ No ___

Name of Drug: _____ Purpose: _____

Name of Drug: _____ Purpose: _____

Are you currently under a **psychiatrist's** care? Yes ___ No ___

If yes, explain: _____

Psychiatrist's Name: _____ Phone Number: _____

Are you currently taking medication(s)? *(attach more sheets if necessary)* Yes ___ No ___

Name of Drug: _____ Purpose: _____

Name of Drug: _____ Purpose: _____

Have you ever been hospitalized for psychiatric purposes (i.e. severe depression, suicide risk, etc.)? Yes ___ No ___

If yes, explain: _____

Date of last admittance:

Prior Counseling Services:

Have you received counseling services before? Yes ___ No ___ For how long? _____

Name of Therapist: _____ Date of Last Session: _____

Reason for seeking services: _____

Current Issue:

Approximate date of onset: _____

Interfering with: (circle) Daily Living Relationships Home School Work Other: _____

Presenting complaint: _____

Were there any precipitating factors (i.e. loss of job, divorce, birth/death, life transition)?: _____

How can I help?: _____

What results are you hoping for?: _____

Client Signature: Date: