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CLIENT INTAKE FORM

Welcome! I am pleased to have the opportunity to work with you. Feel free to discuss and ask questions about any of the policies or information on the intake forms.

CLIENT INFORMATION

CLIENT NAME: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE: _____

TELEPHONE: Home: _____ Work: _____ Cell: _____

E-MAIL ADDRESS: _____ TEXTING OK? YES NO

CLIENT SOC. SEC. #: _____ DATE OF BIRTH: _____

MARITAL STATUS: Single ____ Married ____ Divorced ____ Widowed ____

EMPLOYER: _____ OCCUPATION: _____
(of the parent/legal guardian if client is minor)
ADDRESS: _____

INSURANCE:
Primary insurance company: _____
Provider Department Tel.: _____
Subscriber/Member ID: _____ Group ID#: _____
Main subscriber name: _____
Main subscriber soc. sec.#: _____
Secondary insurance company: _____ Telephone _____
Subscriber/Member ID: _____

Who referred you? _____
May I contact the referral source to thank him/her for referring you? _____
Emergency contact name and phone number: _____

OFFICE USE ONLY:
PAYOR ID: _____

Please check all concerns that apply to you (or your child):

_____ sad, tearful	_____ eating problems	_____ sleep problems
_____ irritable, angry	_____ worried, anxious	_____ overactive
_____ learning difficulties	_____ fighting/conflict	_____ poor self-image
_____ school problems	_____ drug/alcohol abuse	_____ social problems
_____ depressed/hopeless	_____ stressed/upset	_____ family problems
_____ impulsive	_____ poor communication	_____ relationship prob.
_____ work/career difficulties	_____ change in personality	_____ recent loss
_____ recent trauma	_____ past trauma	_____ head injury
_____ medical problems	_____ parenting problems	_____ panic attacks
_____ health concerns	_____ fears	_____ obsessions (intruding thoughts)

_____ compulsions (behaviors that you cannot stop) _____ suicidal thoughts

_____ history/current drug use/abuse. If yes, please list drugs of choice _____
_____

How much alcohol do you drink and how often? _____

_____ Other concerns (explain): _____

Psychiatric hospitalization(s) dates _____

Psychiatric medications _____
_____

Prescribing physician/psychiatrist _____

What would you like to accomplish through therapy?
1.

2.

3.

Have you been in therapy previously? When? How long?
Did you find it helpful? If yes, how so:
If not, why not?