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CLIENT INTAKE FORM

Today's Date: _____

Name: _____

Age: _____

Address: _____

DOB: _____

_____ Zip: _____

SSN: _____

Marital Status: _____

Telephone: _____ (Home)

OK to leave a Message? Yes No

_____ (Work)

OK to leave a Message? Yes No

_____ (Cell)

OK to leave a Message? Yes No

E-mail: _____

Occupation: _____ Employer/School: _____

Level of Education: _____

How did you hear about me? _____ May I acknowledge the referral?

To whom will bills be sent(if different than self)?

Address and Phone (if different than client's):

Emergency Contact (name & phone):

Medical Information

Current Primary Physician: _____ City: _____

Phone: _____ Date of last exam: _____

May I contact your physician to coordinate care if necessary? Yes No

If yes, please sign here to authorize contact:

Current Medical Problems/Issues:

Current Medications and Dosages:

List Below any Significant Medical History (illnesses, surgeries, conditions) Including Dates:

Mental Health Information

Have you ever received counseling, mental health or substance abuse services in the past?

If so, please list below:

| Approximate Dates | Provider/Institution Name | Reason |
|-------------------|---------------------------|--------|
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Have you ever taken medication for psychiatric reasons in the past? _____ If so, please list below:

| Approximate Dates | Name of Medication | Reason |
|-------------------|--------------------|--------|
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Have you ever had psychological testing? _____ If so, approximately when and where?

Has anyone in your family been in counseling or treatment for a mental health or substance abuse condition? _____ If so, please list below:

| Relative | Condition and/or Treatment |
|----------|----------------------------|
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Insurance Information (if applicable)

Policy #1:

Insured party: _____ Relation to you: _____
 Date of Birth (if not you): _____ Social Security Number: _____
 Insurance Company: _____ Policy/ID#: _____
 Address for Claims: _____ Group #: _____
 _____ Employer: _____ Telephone
 Number: _____ Effective Date: _____
 Amount of Deductible: _____ Amount of Deductible Met (if any): _____
 Percentage of Fee Covered: _____ Reimbursable Fee Limit (if any): _____

Number of sessions allowed per year:

Policy #2:

Insured party: _____ Relation to you:
Date of Birth (if not you): _____ Social Security Number:
Insurance Company: _____ Policy/ID#:
Address for Claims: _____ Group #:
_____ Employer: _____ Telephone
Number: _____ Effective Date:
Amount of Deductible: _____ Amount of Deductible Met (if any):
Percentage of Fee Covered: _____ Reimbursable Fee Limit (if any):
Number of sessions allowed per year: