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Intake Form

Client name: _____ Birth date: _____

Contact information:

Home phone: _____ May I leave a message? ☐ yes ☐ no
Work phone: _____ May I leave a message? ☐ yes ☐ no
Cell phone: _____ May I leave a message? ☐ yes ☐ no
Email: _____ May I email? ☐ yes ☐ no

Primary address: _____
City: _____ State: _____ Zip: _____

Other address: _____

Person to contact in an emergency:

Name:_____ Relationship: _____

Phone: __(_____)_____

Names of individuals in the primary household:

First & last name	Relationship to client	Employer or school	Highest level of education
Additional household members / second household			

Religious and cultural background:

Cultural background: _____
Religion: _____
Importance of religion to you/your family:
☐ Important ☐ Somewhat important ☐ Not important

Brief medical history:

Family physician: _____ phone: (___)_____

Psychiatrist:_____ phone: (___)_____

Please list any illnesses or medical conditions (client): _____

_____

_____

Past suicidal thoughts/attempts: Dates of treatment (if applicable):

_____

_____

Family history of any illnesses or medical conditions (e.g. mental health concerns, alcohol/substance abuse, hospitalizations): _____

_____

_____

Current medications:

Medication	Dosage	For treatment of…	Start date	Prescribing physician

Previous therapy: _____

_____

Reason for seeking treatment/current concerns: _____

_____

What are the symptoms? _____

_____

Date of first symptoms: _____

Is there anything else you want me to know or think that I should know? _____

_____

_____

Date of first visit: _____

Referred by: _____