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CLIENT INTAKE FORM
Please complete all pages of form.

Client's Full Name: _____ Social Security#: _____

Date of Birth: _____

Gender at Birth: _____ Current gender identification: _____ Identified Pronouns: _____

Referred by: _____ Primary Care Physician: _____

Client lives with: Mother Father Both Other: _____

Mothers Name: _____ Social Security#: _____

Fathers Name: _____ Social Security#: _____

Client's Address: _____

Home Phone: _____ day evening OK to leave msg? YES NO

Work Phone: _____ day evening OK to leave msg? YES NO

Cell Phone: _____ day evening OK to leave msg? YES NO

PRIMARY INSURANCE INFORMATION
(information found on insurance card)

Insurance Company: _____ Phone#: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Relationship to client: _____

ID#: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION
(information found on insurance card)

Insurance Company: _____ Phone#: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Relationship to client: _____

ID#: _____ Group/Plan #: _____

COUNSELOR'S NOTES (for office use only)

Date	dx code	dx	Counselor Signature

MEDICAL HISTORY

How is your general health? Excellent Good Fair Poor

Briefly describe your primary concerns and why you have sought counseling at this time:

When was your last comprehensive medical evaluation? _____

Have you ever been hospitalized for psychological reasons? Yes No

If yes, when and where? _____

Please check whether you currently have, or have ever had any of the following:

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> drug/alcohol abuse | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> changes in appetite | <input type="checkbox"/> flashbacks |
| <input type="checkbox"/> running away | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> epilepsy or seizures | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> disturbing thoughts | <input type="checkbox"/> lack of interest | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> depression |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> low self-esteem | <input type="checkbox"/> speech problems | <input type="checkbox"/> confusion |
| <input type="checkbox"/> irritability | <input type="checkbox"/> emotional abuse | <input type="checkbox"/> hearing problems | <input type="checkbox"/> seizures |
| <input type="checkbox"/> bowel problems | <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> visual problems | <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> suicidal ideations/attempts | <input type="checkbox"/> feelings of hopelessness | <input type="checkbox"/> homicidal thoughts | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> sexual concerns | <input type="checkbox"/> difficulty managing anger | <input type="checkbox"/> mood swings | <input type="checkbox"/> asthma |
| <input type="checkbox"/> chronic illnesses | <input type="checkbox"/> family/relationship issues | <input type="checkbox"/> communication problems | <input type="checkbox"/> stress |
| <input type="checkbox"/> phobias: _____ | <input type="checkbox"/> hormone disorder | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> physical abuse or neglect | <input type="checkbox"/> panic attacks | <input type="checkbox"/> serious infection | <input type="checkbox"/> allergies |
| <input type="checkbox"/> racing thoughts | <input type="checkbox"/> frequent stomachaches | <input type="checkbox"/> feelings or paranoia | <input type="checkbox"/> head trauma |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> school/work difficulties | <input type="checkbox"/> blood pressure concerns | |
| <input type="checkbox"/> problems with coordination | <input type="checkbox"/> frequent or | <input type="checkbox"/> self-destructive or | |
| <input type="checkbox"/> gender issues | uncontrolled crying | self-injurious behavior | |

Other physical or emotional issues (please describe):

Are you currently taking medication? Yes No

Medication: _____ Dosage: _____ Date Started: _____

Medication: _____ Dosage: _____ Date Started: _____

Medication: _____ Dosage: _____ Date Started: _____

List any serious illnesses for which you have required hospitalization or surgical operation:

Illness	Year	Doctor	Hospital

Has you ever received psychological, substance abuse, or psychiatric services?

Service	Year	Doctor	Issue at Time

FAMILY SITUATION

Relationship/Marital Status of parents: Single Involved Engaged Cohabiting
 Remarried Married Separated Divorced Widowed

Names and ages of other individuals residing in the home:

Name	Age	Relationship to Client

Client's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Father's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Mother's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Are there any family members who have experienced significant medical problems, mental health problems or substance abuse?

(Please indicate relationship to child):

Medical Problems-

Past: _____

Present: _____

Alcohol Use-

Past: _____

Present: _____

Drug Use-

Past: _____

Present: _____

Tobacco Use-

Past: _____

Present: _____

Caffeine Use-

Past: _____

Present: _____

GOALS FOR THERAPY

What would you like to see happen as a result of your work here? _____
