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|  | Client Intake Form |  |  |
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|  | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | | | | | | Client Name | | | | | | Client Information | | | | | | | | | | | |  | | | | | | | | | | | |  | |  | |  | | | |  | |  | | Home Phone | | | Cell Phone | | | | | | Email Address | | |  | | | | | | | | | | | | Address | | | | | | | | | | | |  | |  | |  | | | |  | |  | | City | |  | | State | | | |  | | ZIP Code | |  | | | | | | | | | | | | Reason for seeking care | | | | | | | | | | | |  | | | | |  | |  | | | | | DOB | | | | |  | | Gender | | | | |  | | | | |  | |  | | | | | Occupation | | | | |  | | Medical History | | | | |  | | | | |  | |  | | | | | Current Treatment | | | | |  | | Counseling/Psychiatric History | | | | |  |  | | | | | |  | Referred by | | | | | | |  |