**CLIENT INTAKE FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Intake: | | | |
| Name: | Date of Birth: | | |
| Street Address | | | |
| City, State, Zip: | | | |
| Home Phone: | May I call and leave a message?: Yes No | | |
| Cell Phone: | May I call and leave a message?: Yes No | | |
| Work Phone: | May I call and leave a message?: Yes No | | |
| Insurance Carrier: | Insurance ID #: | | |
| Name of Employer: | | | |
| Work Position: | | | |
|  | | | |
| Marital Status: Single Cohabitating Married Separated Divorced Widowed | | | |
| **Household members, include custody status if child:** | | | |
| Name: | Age: | | Custody status: |
| Name: | Age: | | Custody status: |
| Name: | Age: | | Custody status: |
| Name: | Age: | | Custody status: |
| Name: | Age: | | Custody status: |
| Emergency Contact Name: | | | |
| Emergency Contact Phone #: | | Relationship to individual: | |
| **Treatment of Minor Child:** I, the undersigned, attest that I give my consent for the treatment of: | | | |
| Child Name | | Grade: | |
| Parent/Legal Guardian Name: | | Signature: | |
| Do you have any medical conditions that may affect your treatment? Yes No | | | |
| Date of last visit to Physician: | | | |
| Please describe your overall health today: | | | |
|  | | | |
| Do you drink alcohol? Yes No If yes, how much do you consume in a week?: | | | |
| Do you currently use drugs (street, non-prescription or herbal supplements)? Yes No If yes, please describe: | | | |
|  | | | |

**MEDICAL HISTORY:**

Are you currently taking any prescription medication? Yes No If yes, please list below:

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Prescriber Name |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)**

• None = This symptom not present at this time

• Mild = Impacts quality of life, but no significant impairment of day-to-day functioning

• Moderate = Significant impact on quality of life / functioning

• Severe = Profound impact on quality of life / functioning

|  |  |  |  |
| --- | --- | --- | --- |
|  | **None Mild Moderate Severe** |  | **None Mild Moderate Severe** |
| Depressed Mood |  | Hyperactivity |  |
| Appetite Disturbance |  | Delusions |  |
| Sleep Disturbance |  | Hallucinations |  |
| Fatigue/Low Energy |  | Aggressive Behaviors |  |
| Poor Concentration |  | Binging/Purging |  |
| Mood Swings |  | Anorexia |  |
| Agitation |  | Weigh loss/gain |  |
| Elevated Mood |  | Family Conflict |  |
| Emotionality |  | Hopelessness |  |
| Irritability |  | Grief |  |
| Social Isolation |  | Sexual Problems |  |
| Worthlessness |  | Phobias |  |
| Panic Attacks |  | Obsessions/Compulsions |  |
| Self-Inflicted Wounding |  | Difficulty Making Friends |  |
| Financial Problems |  | Difficulty Keeping Friends |  |

What brings you into therapy today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did the issue arise?

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What kind of support system do you have?

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