CLIENT INFORMATION

Please provide the following information for our records and complete to the best of your ability. Information you provide here is held to the same standards of confidentiality as our therapy. Please bring intake forms to your first session or allow yourself 15 to 30 minutes prior to your appointment to complete in the office.

First name: ___________________________Middle initial: ____Last name: ______________________________

Date of birth: __________Age: ______ Race/Ethnicity: _________________ Gender identity: ______________

Address: ____

City: ____ State: ________________ Zip: ________________

Home Phone: _____________________________________ Cell: ____

Work: ____ E-mail: _____________________________________

Permission to text: ☐ Yes ☐ No Voicemail permission: ☐ Yes ☐ No Permission to E-mail: ☐ Yes ☐ No

Marital Status: ☐ N/A ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Children's Names and Ages:____

Name of Parent/Guardian 1: (if under age 18) _________________________________ Relation: ______________

Custody? ☐ Yes ☐ No D.O.B. __________ Phone: __________________ E-mail: _________________________

Name of Parent/Guardian 2: (if under age 18) _________________________________ Relation: ______________

Custody? ☐ Yes ☐ No D.O.B. __________ Phone: __________________ E-mail: _________________________

Emergency contact name: ______________________________________ Relationship: _____________________

Home phone: ____________________Cell phone: ___________________Email: ___________________________

(If emergency contact is not the legal guardian a consent for release of information will need to be signed. See therapist to request form)

Primary Care Physician: ____ Phone: _________________________

Psychiatrist (if applicable): _______________________________________ Phone:__________________________

Referral Source: ____ Phone: _________________________

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Resilient Hearts Therapy

(**CLIENT INFO Cont.**)

Please describe reasons for seeking treatment at this time:

____

____

____

Have you previously received any type of psychological/psychiatric treatment? (please explain): ______________

____

What did you like/dislike? ____

What was most/least helpful? ____

Current Medications and Dosages (if applicable): ____

____

Current Physical Health Conditions/Medications: ____

____

Please indicate any information about you that will be pertinent in helping you at this time

(Including any family psychological/medical history, legal issues):

____

____

____

Please briefly state your goals for therapy:

____

____

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____ ______________________

Client/Guardian Signature Date

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