

INTAKE FORM

Date: _____

How did you hear about me: _____

Client Name: _____ D.O.B _____ Age: _____

Address: _____

Phone Numbers: Cell: _____ Belongs to: _____

Cell: _____ Belongs to: _____

Email address: _____ Belongs to: _____

Are you married: _____ How long: _____

Names of any children and their ages:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Emergency contact: _____ Phone #: _____

Previous counseling: _____ Name of counselor: _____

Date of last appt: _____ Reason for ending therapy: _____

Primary Care Physician: _____ Phone #: _____

Medications:

Have you ever been suicidal: _____ If yes, how and when?:

Have you ever had any criminal activity or arrests: _____

If so, when were you arrested and what was the reason for the arrest:

Has there been a DWI: _____ How many: _____

Do you currently have any substance abuse issues: _____

What drugs have you used:

What is your drug of choice: _____

Do you feel that you need treatment for substances: _____

If so, are you willing to accept help: _____

Reasons for seeking therapy:

How long have these concerns persisted:

Goals for therapy:

Signature: _____ Date: _____
