Elizabeth A. Snyder MS, LMHC
Mental Health Services for Adolescents and Young Adults

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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? Y N
Work Phone:_____ ☐ day ☐ evening OK to leave msg? Y N
Cell Phone:_____ ☐ day ☐ evening OK to leave msg? Y N

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:

__drug/alcohol abuse	__sleeping problems	__changes in appetite	__flashbacks
__running away	__frequent headaches	__epilepsy or seizures	__ulcers
__disturbing thoughts	__lack of interest	__sexual abuse	__depression
__memory problems	__low self-esteem	__speech problems	__confusion
__irritability	__emotional abuse	__hearing problems	__seizures
__bowel problems	__irregular heartbeat	__visual problems	__bedwetting
__weight loss	__sexual concerns	__difficulty managing anger	__mood swings
__asthma	__chronic illnesses	__stress	__anxiety
__hormone disorder	__difficulty concentrating	__physical abuse or neglect	__panic attacks
__serious infection	__allergies	__racing thoughts	__head trauma
__frequent stomachaches	__feelings of paranoia	__broken bones	__gender issues
__family/relationship issues	__communication problems	__phobias:_____	
__blood pressure concerns	__school/work difficulties	__problems with coordination	
__suicidal ideations/attempts	__feelings of hopelessness	__homicidal thoughts	
__frequent or uncontrolled crying		__self-destructive or 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: _____
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 ☐ Cohabitating ☐ 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 client):
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?_____

_____

_____

_____