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Licensed Clinical Social Worker #LW60061289

CLIENT INTAKE FORM

Date:_____.

Client Name:_____ Date of Birth:_____.

Name of parent/legal guardian (if client is under age 18)_____.

Client Address:_____.
City State Zip

Phone #'s: (H)_____ (W)_____ (C)_____.

E-Mail:_____.

Referral source:_____.

Employer/School:_____ Occupation:_____.

Primary Insurance:_____ ph:_____.

Name coverage is through:_____ Relation to client:_____ DOB:_____.

Insurance ID#:_____ Group#_____.

Copay amount:_____.

Current reason for seeking counseling: _____

_____

_____

Goals for therapy:_____

_____

_____

History/current medical problems:

Current Medications:_____.

Primary Care Physician:_____ ph:_____.

Experience with therapy (when, how long, with whom):_____.

_____.

Current family or living situation:_____.

_____.

Emergency Contact:_____ ph:_____.

Emergency Contact (for your child):_____ ph:_____.

Relationship: _____.

Do you (the client) have children?

Children: Name_____ M__ F__ Age____.

Children: Name_____M__ F__ Age____.

Does your child have a physical condition? Y__ N__.

-If Yes, please explain:_____.

Is your child taking prescription medication? Y__ N__.

-If Yes, please list:_____.

Is your child currently in mental health treatment including therapy or counseling? Y__ N__

-If yes, please list where you or your child is currently being treated:
Name of Therapist:_____.

Address:_____. Ph: _____.