Heal Together Counseling: Client Intake Form

Name: _____

Nickname: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian 1:

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian 2:

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent Relationship Status:

Single Married Partnered Divorced Separated Widow(er)

Emergency Contact (if different from parent):

Name: _____ Relationship to client: _____

Address: _____

City: _____ State: _____ Phone: _____

Insurance Information:

Insurance Carrier: _____

Phone Number: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber DOB: _____

Secondary Insurance Information:

Insurance Carrier: _____

Phone Number: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber DOB: _____

Medical Information:

Prior Therapy? Yes No When: _____ Where:_____

Primary Care Physician: _____

Phone Number: _____ Last Physical: _____

Current Medications:

Current Medication	Dosage	Prescriber

Current Diagnosis: _____

Prior Testing: None Neuropsychological Educational Psychological

Testing Date: _____ Testing Agency: _____

School Information:

School Name: _____ Grade: _____

Special Education: None IEP 504

Services (circle): OT PT Speech Other: _____

School Concerns: _____

Dept. of Children, Youth & Families:

Involvement in DCYF: None Prior Current

If yes, reason for involvement: _____

Legal authority to sign for client: _____

CPSW: _____ Phone: _____

Military Service:

Has anyone in your family served in the military? Yes No

Who: _____

Branch: Army Navy Air Force Marines Coast Guard National Guard

Status: Active Duty Reserves Inactive Ready Reserves Veteran

Has anyone in your family experienced a deployment?

Who: _____ When: _____

Challenges: _____

Observations:

What are your major concerns: _____

_____

_____

How long have these issues been a concern: _____

Does your child have a history of any of the following (circle all that apply):

Suicidal Thoughts Suicide Attempts Homicidal Thoughts Homicidal Attempts

Family History (physical/mental health diagnosis):

Mother: _____

Father: _____

Siblings: _____

Other: _____

Child Likes/Dislikes:

_____

_____

Anything else to share:

_____

_____

_____

Referred By:

Name: _____ May I Thank Them? Yes No

Address: _____