CLIENT INTAKE FORM

INSTRUCTIONS: PLEASE COMPLETELY FILL OUT BOTH SIDES.

Name: Social Security #:

Address:_____
City/State/Zip:

Home Phone # Work Phone # Cell Phone#
OK to leave message? YES / NO

Date of Birth: Referred by:

Gender: FEMALE / MALE Primary Care Physician:

PRIMARY INSURANCE

Insurance Co.:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #:

Insured's Name:_____
Relationship to you:_____
Insured's ID#:_____
Group/Plan #:_____
Insured's Address:_____
_____
Insured's Phone #:

SECONDARY INSURANCE

Insurance Co.:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #:

Insured's Name:_____
Relationship to you:_____
Insured's ID#:_____
Group/Plan #:_____
Insured's Address:_____
_____
Insured's Phone #:

PERSONAL INFORMATION

Where were you born/raised?_____
EDUCATIONAL LEVEL (circle): 8 9 10 11 12 13 14 15 16 17 18 19+
OCCUPATION:_____
EMPLOYER:_____ How long have you worked there?_____
EMERGENCY CONTACT & PHONE:

MEDICAL HISTORY

ALL CURRENT MEDICATIONS (Including herbal and over-the-counter):

Medication	Dosage	Date Started

SIGNIFICANT MEDICAL PROBLEMS
Past:_____
Present:_____
ALLERGIES:_____
ALCOHOL / DRUG / TOBACCO / CAFFEINE USE
Past:_____
Present:_____
Have you had previous counseling? YES / NO
If yes, with whom?_____ When?_____

FAMILY SITUATION

RELATIONSHIP/MARITAL STATUS: single involved engaged cohabitating married separated divorced widowed

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

Partner/Spouse	Beginning Year	Ending Year	Names/ages of children from relationship	Where/with whom do they live?

GOALS FOR THERAPY

What would you like to see happen as a result of your work here?_____
_____
_____
_____