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**Client Intake Form**

Client Name: \_\_\_\_\_ Intake Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_

OK to leave a message? Y N

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Home Address, City, ZIP: \_\_\_\_\_

E-mail: \_\_\_\_\_ May we email you (billing & correspondence)? Y N

\*Please be aware that email may not be confidential.

Referred by \_\_\_\_\_

Are you employed? Y N Name and length of current employer: \_\_\_\_\_

Relationship Status: Single Married Domestic Partner Separated Divorced Widowed

Name(s) and age(s) of children: \_\_\_\_\_

Please list other persons living in your household and their relationship to you:

\_\_\_\_\_

Are there legal reasons why you are seeking therapy? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Name of Primary Care Physician (PCP): \_\_\_\_\_

PCP telephone number: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Health Insurance Information: \_\_\_\_\_

Please list any physical complaints or health concerns \_\_\_\_\_

List any family history of mental illness \_\_\_\_\_

Are you currently taking any medications for psychiatric reasons? Yes or No

If yes, list name, dosage, and physician's name: \_\_\_\_\_

\_\_\_\_\_

**Person to contact in case of an emergency, and AUTHORIZATION to contact and release relevant information to person(s) said below in event of an emergency.**

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:

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2. Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial situation	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual functioning	1	2	3	4	5	N/A
Alcohol/Drug Usage	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control your temper	1	2	3	4	5	N/A

3. What result(s) do you expect from treatment?

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4. Have you received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought:

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