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Client Intake Form

Demographic Information Date: ____________________

Name: ____ Date of Birth: ______________ Age: ________

Nickname: __________________________ Gender: ______ Social Security #: ______________________

Address: ____

City: ____ State: ______ Zip: _____________

Only list phone numbers and email addresses where you are comfortable being reached.

Home #: ___________________ Work #: ______________________ Cell #: ______________________

Primary Email: ____________________________ Alternate Email: ______________________________

Education (circle highest level completed): High School Undergraduate Graduate Doctorate

Occupation: ________________________________ Employer: ___________________________________

Insurance Information

Note: We do not directly participate with any insurance company. The client is solely responsible for all payments of services and interactions with insurance company.

Name of Insurance Company: __________________________________ Phone: ___________________

Policy #: _______________ Group #: __________ Name of Policy Holder: ________________________

Address of Policy Holder (if other than above): ____

Phone # of Policy Holder: cell _______________________ work____________________________

Relationship to Policy Holder: ______________________ Date of Birth Policy Holder: ______________

Soc Security # Policy Holder: ________________ Employer of Policy Holder_____________________

Emergency Contact

Name: ______________________________ Relationship: ________________ Phone: ________________

Name: ______________________

Medical Information

Primary Care Physician: ____ Phone: ____________________

Have you seen your Primary Care Physician in the past 12 months: Yes No

(We strongly recommend that all clients have a physical examination at least every 12 months.)

Name and phone number for other physicians you are currently seeing:

____

____

Please list the medications you are currently taking:

Medication	Dose	Reason

Please list any current medical problems

____

____

Family Information

Marital status: Single Dating Married Separated Divorced Widowed Other ____________

List the name, age, and relationship of all people living within your home

Name	Age	Relationship

List the name and age of children not living in your home

Name	Age

Name: ______________________

Counseling

What has brought you into counseling?

____

____

Previous counseling? Please list approximate dates and name of counselor

____

____

Previous hospitalizations for these conditions? Please list approximate dates and facility

____

____

Do you have any other concerns today?

____

____

Faith

Particular religious denomination/affiliation: ________________________________

How involved are you in your faith:

Not involved at all	Attend services occasionally	Attend services weekly	Attend services more than once per week

Would you want your therapist to integrate faith in planning and implementing your treatment?

Yes _____ No _____ Unsure _____

Referral

How did you hear about us?

____

____