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Intake Form

NAME OF CLIENT:_______________________________________DOB:________________

NAME OF PARENT/GUARDIAN (if client is a minor) ________________________________

ADDRESS: ____

Cell Ph: ( )__________________________Other Ph: ( )___________________________

Is it okay to text you on your cell phone to leave messages? YES______ NO______

Email: ___________________________Sponsor's SSAN: ____________________________

Education: _________________________ REFERRED BY:___________________________

PERSON AND TEL. NO. TO CALL IN EMERGENCY: ______________________________

MARITAL STATUS: _________________________

OCCUPATION/POSITION: ____

INSURANCE INFO: ____

MEDICAL DOCTOR(S): ____________________________ PHONE(S): _______________

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations):

____

CURRENT MEDICATIONS: ____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/PSYCHIATRIC HOSPITALIZATION:

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):

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FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

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PRESENTING PROBLEM/AREAS OF CONCERN:

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