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CLIENT INTAKE FORM

Today's date: _____

Client name:_____Preferred name: _____

Who referred you to me? _____

Home address:

_____, _____, _____
street address city zip

Home #_____ Cell # _____Work # _____

Is it safe/ok to call you at these numbers and leave messages? YES NO

Email address: _____

Is it safe/ok to email you at this address? YES NO

Are you ok with emails and/or texts to remind you about appointments? YES NO

If yes, which do you prefer? EMAILS TEXTS

Date of birth: _____ Age: _____ Gender: _____

Your preferred pronouns: _____

Race/Ethnicity: _____ Country of origin: _____

Disability status : _____

Religious affiliation or spiritual practice: _____

Highest educational level obtained: ___ some high school ___ high school graduate or GED

____some college ___ college graduate ___ some graduate school ___ doctoral degree

Job title/Occupation: _____Employer: _____

Primary care provider: _____ Last exam: _____

Psychiatrist: _____Last appt: _____

Relationship status: _____

If currently in a relationship, length of relationship: _____

Dependents (names, ages):_____

Emergency contact: _____Relationship: _____

Contact #s: _____

Current or past medical issues/problems:

Current medications and dosages:

Prior treatment: Beginning with the most recent, please list all professionals and facilities that have provided mental health evaluation and/or treatment.

TYPE OF SERVICE PROVIDER(S) DATE(S) OF SERVICE

Family history of mental illness? YES NO

If yes, Relationship:_____ Diagnosis/Issue:_____

Current functioning: _____

Has anyone in your family ever attempted/completed suicide? If so, whom and when?

Have you ever attempted suicide? If so, when?

Have you ever been hospitalized? If so, where and when?

Briefly describe the reasons that bring you here:

What would you like to achieve by seeking care?

Signature_____ Date: _____

Printed name _____