

CLIENT INTAKE FORM

GENERAL DEMOGRAPHICS:

Name: _____ Today's Date: _____/_____/_____
(Last) (First) (MI) (Month) (Day) (Year)

Birth Date: ____/____/____ Age: ____ Gender: Male Female Social Security #: _____
(Month) (Day) (Year)

Home Address: _____
(Street and Number) (City) (State) (Zip Code)

Mailing Address: _____
(Street and Number) (City) (State) (Zip Code)

Which Address Is Used For Insurance/Billing Purposes? Home Mailing

Home Phone: __ (____) _____ May I leave a message at this number? Yes No

Cell Phone: __ (____) _____ May I leave a message at this number? Yes No

Work Phone: __ (____) _____ May I leave a message at this number? Yes No

What is your preferred contact phone number? Home Cell Work

Marital Status: Single Married Separated Divorced Widowed

Are You Employed? Yes No If yes, Employer: _____ Job Title: _____

Are You A Student? Yes No If yes, School Name: _____

Emergency Contact Name: _____ Relationship: _____
(Last) (First)

Emergency Contact Phone: __ (____) _____

Where Did You Find My Name? _____

Referring Physician (if applicable): _____

HEALTH INSURANCE/BILLING INFORMATION:

Patient Relationship To Insured: Self Spouse Partner Other Insured's Gender: Male Female

Insured's Name: _____ Insured's Birthdate _____/_____/_____
(Last) (First) (MI) (Month) (Day) (Year)

Primary Insurance Name: _____ ID#: _____ Group # _____

Secondary Insurance Name: _____ ID#: _____ Group # _____

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PROBLEM ANALYSIS:

Problem Description: Please describe, in brief terms, the nature of the problem or concern that you need help with:

Problem Intensity: How would you rate the intensity of the problem or concern that you have?

- Not Intense Somewhat Intense Moderately Intense Quite Intense Very Intense

Problem Duration: Approximately how long has your problem or concern been going on? _____

Symptom List: Please indicate which of the following symptoms, emotions, feelings, or behaviors apply to you.

- Hopeless Sad Change in Appetite Thoughts of Hurting/Killing Yourself/Others
 Anxious Panicky Change in Sleeping Habit Change in Sexual Interest/Function
 Depressed Tearful Hear/See Strange Things Problem With Interpersonal Relationships
 Angry Forgetful Extreme Happiness/Sadness Purging (Self-Induced Vomiting)

Coping Attempts: Please describe by what manner or means you have attempted to cope with your problem or concern.

GENERAL HEALTH & MEDICAL ISSUES:

How would you describe your physical health? Poor Unsatisfactory Satisfactory Good Very Good

Do you have any persistent medical problems/health concerns (e.g. chronic pain, diabetes, etc.)? Yes No

Are you currently taking any prescription medication to treat a medical condition? Yes No

If yes, please indicate what medication and how long you have been taking it (insulin/3 years, etc.):

If you are taking prescription medication, who prescribed it to you? _____
(Last) (First)

How many times per week do you exercise? _____ **For about how long each time?** _____

PSYCHIATRIC HISTORY:

Are you currently receiving psychiatric treatment or psychological counseling elsewhere? Yes No

If yes, what is the name of your counselor, how long have you been receiving treatment, and for what reason?

Have you ever received psychiatric treatment or psychological counseling in the past? Yes No

If yes, what was the name of your counselor(s), when were you in treatment, for how long, and for what reason?

Have you ever been hospitalized in a psychiatric treatment facility in the past? Yes No

If yes, where were you hospitalized, for how long, and for what reason?

Are you currently taking any prescribed psychiatric medication? Yes No

If yes, what is the name and dose of the medication(s), how long have you been taking it, and for what reason?

If you are not currently taking prescription medication, have you ever done so in the past? Yes No

If yes, what was the name of the medication(s), how long were you taking it, and for what reason?

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PERSONAL/CULTURAL BACKGROUND:

Education:

Did you graduate from high school? Yes No (child) If not, please indicate highest grade completed: _____

Have you ever attended a college or university? Yes No If so, did you graduate? Yes No

Please indicate the type of degree that you may possess: AA BA/BS MA/MS Other _____

Military:

Have you ever been a member of the Military? Yes No If so, are you currently on active duty? Yes No

What is your current, or what was, your rank? _____

Ethnicity:

What is your ethnic identity? _____

How much do you identify with your heritage? Not at all A little Somewhat Moderately Strongly

Religion:

Do you consider yourself a religious person? Yes No If so, what is your religious preference? _____

Are you currently active in your religion? Yes Somewhat Not at all

Family History:

Do you have any children? Yes No If so, please list gender and ages (e.g. son/4, daughter/8, etc.):

Do you have any stepchildren? Yes No If so, please list gender and ages (e.g. son/4, daughter/8, etc.):

Please list the identity and age of all *living* members of your immediate family (e.g. father/65, wife/28, brother/21, etc.):

Please list the identity and age of all *deceased* members of your immediate family (e.g. father/65, wife/28, brother/21, etc.):

Please check any past, present, or impending special problems in your family:

- divorce debilitating injuries/disabilities alcohol/drug abuse psychiatric disorder serious illness
- physical/sexual abuse financial crisis/unemployment legal problems attempted/completed suicide
- eating disorders other (please specify) _____

Please specify family member(s), special problem, and approximate year of occurrence (e.g. father/disability/1997):

Have you personally experienced significant family abuse? No Unsure Emotional Physical Sexual

How happy or adjusted were you growing up? Not very Somewhat Average Above average Very

How much is your immediate family a source of emotional support for you?

- Not at all A little Somewhat Substantial Very much so

Who in your family do you currently feel closest to? _____

Who in your family do you currently feel most distant from? _____

Who in your family do you feel most in conflict with? _____