# CLIENT INTAKE FORM

NAME:___________________________________ DATE:_______________ DOB:_________________

PREFERRED CONTACT NUMBER: ______________ ALTERNATE NUMBER (optional): ___________

ADDRESS:___________________________________________________________________________

CITY:___________________STATE:___ ZIP:_________ Receive mail at this address? YES___ NO___

EMAIL:_______________________________________Receive email at this address? YES___NO___

How do you prefer to receive automated appointment reminders?

TEXT ONLY___ EMAIL ONLY ___TEXT AND EMAIL ___ PHONE CALL, TEXT, AND EMAIL ____

Age:______ Marital Status:_________ Ethnicity:____________________ Religion:________________

Occupation:__________________________________ Employer:_________________________________

Number of Years:_________ Highest Education Completed:____________________________________

How did you hear about us? Insurance___ Internet Search___ Psychology Today___ Practice Website___ Referred by doctor or other clinician___ (Please list clinician's name here:_______________________) Referred by friend or family member _______ Social Media______ Other___(Please list:____________________________________________________________)

## EMERGENCY CONTACT INFORMATION

NAME:________________________ PHONE:____________________ RELATIONSHIP:___________

BRIEFLY DESCRIBE WHAT IS BRINGING YOU IN (e.g. depression, anxiety, relationship counseling)

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

HAVE YOU SOUGHT MENTAL HEALTH SERVICES BEFORE? If yes, please list providers seen and dates of service, and diagnoses.

______________________________________________________________________

______________________________________________________________________

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MEDICAL CONDITIONS/DIAGNOSES: (e.g. diabetes, seizures, hx of cancer, bariatric surgery)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

CURRENT MEDICATIONS: (Please include dosages and prescribing physician.)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

LEGAL HISTORY: (Please include any arrests, convictions, charges, and sentencing information).

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

ALCOHOL AND/OR RECREATIONAL DRUG USE: (e.g. How many drinks per week/frequency of use? If you are in recovery, please indicate how long you have been sober and any recovery programs you participate in, such as AA/NA)____________________________________

______________________________________________________________________

______________________________________________________________________