Client Intake Form

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Today's Date: _____

Referred by:_____

PERSONAL INFORMATION

Name:_____ Age:_____ Sex:_____

Address:_____ Own/Rent:_____

City, State, Zip:_____ Date of Birth:_____

Home Phone:_____ May I call this number? Y N May I leave a message? Y N

Cell Phone:_____ May I call this number? Y N May I leave a message? Y N

Email: _____ May I email you appointment reminders? Y N

(Note: Email is not considered secure. I use it for appointment reminders & to arrange and modify appointments only.)

Person responsible for bill:_____ Relationship:_____

Address & Phone of responsible party:_____

EMERGENCY CONTACT

Emergency Contact:_____ Relationship:_____

Address:_____

Home Phone:_____ Work Phone:_____

INSURANCE INFORMATION

Primary Coverage

Name of Insured:_____ Social Security #:_____ DOB:_____

Insurance Company:_____

Subscriber ID#:_____ Group #:_____

Secondary Coverage

Name of Insured:_____ Social Security #:_____ DOB:_____

Insurance Company:_____

Subscriber ID#:_____ Group #:_____

EMPLOYER

Employer:_____ Job Title:_____ From/To:_____

Address:_____

Work Phone:_____ May I call this number? Y N May I leave a message? Y N

Previous Employer(s):_____ Job Title:_____ From/To:_____

EDUCATIONAL HISTORY

History of learning difficulties? Y N Describe:_____

High school: _____ Graduated? Y N Date of graduation:_____

College or Professional School_____ Degree earned and date:_____

College or Professional School_____ Degree earned and date:_____

College or Professional School_____ Degree earned and date:_____

MEDICAL & REFERRAL INFORMATION

Primary Care Physician:_____ Phone:_____

Other Physicians:_____ Phone:_____

May I share session notes with your physicians? Y N **(Note: Insurance requirements may necessitate)**

Who referred you? _____ Relationship:_____

PERSONAL MEDICAL HISTORY

(Note: Many insurance companies and Medicare require that I obtain detailed medical information)

Have you ever had or do you currently have any of the following: (check all that apply)

___Head injury with loss of consciousness
___Intracranial hemorrhage
___Memory or cognitive problems
___Cancer
___Diabetes
___High Cholesterol
___Coronary artery disease
___Heart attack/myocardial infarction
___Heart problems
___High blood pressure
___Stroke
___Seizures
___Kidney failure/renal disease
___Thyroid or adrenal problems
___Chronic fatigue
___Fibromyalgia
___Chronic pain (Where:_____)
___Eye problems (Glaucoma, etc)
___Menstrual problems
___Peri or post menopausal problems
___Urination, bowel problems, constipation (circle which)
___Sexually transmitted disease or HIV
___Asthma
___Allergies (Name:_____)
___Allergies to Meds (Name:_____)
___Eating problems or eating disorder
___Sleeping problems, insomnia, hypersomnia (circle which)
___Sleep apnea If yes, CPAP use? Y N
___Tobacco use (What, how much:_____)
___Current alcohol use: What, drinks per week:_____
___Past heavy alcohol abuse (List details below)
___Recreational drug use: Current Past (List details below)
___Substance abuse problem or treatment (List details below)
___Trauma, abuse history: Emotional, physical, sexual (circle which)
___Self-harm behaviors: Cutting, burning, other (circle which)
___Suicide attempt (List details below)
___Psychiatric hospitalization (List details below)
___Mood problems or mood related diagnosis (List details below)
___Mood, psychiatric problems/diagnoses in family members)
___Previous therapy: Individual, couples, group (circle which)

Please provide details for medical issues listed on previous page. Please also list any other significant medical problems not noted above. Attach additional pages if necessary:

_____
_____
_____
_____
_____
_____

Please list all physicians treating current medical conditions: _____
_____
_____

CURRENT MEDICATIONS

Please list all prescriptions, over-the-counter medications, & herbal/vitamin supplements. Please also list prescribing physician, dose and frequency. You may attach a typed list.

_____
_____
_____
_____
_____

CURRENT HOUSEHOLD INFORMATION

Spouse/Partner Name:_____

Spouse/Partner's Employer:_____ Work Phone:_____

Others in home (name):	Gender:	Age:	Relationship:
_____	M F	_____	_____
_____	M F	_____	_____
_____	M F	_____	_____

Pets:_____

Unusual household situations:_____

_____

MARITAL HISTORY AND CHILDREN

Single/never married Married Separated Divorced Widowed Unmarried living with partner

If currently married, when were you married: _____

If living with someone, since when: _____

If widowed, circumstance and date of spouse's death:_____

Previous marriages – Please list name of former spouse(s) and dates married:_____

_____

_____

Children:

Name	Age	Marital Status	Place of residence	Bio/Adopt/Step
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY INFORMATION

Parents: Please list biological, adoptive and/or step-parents:

Name	Living?	Age	Date & cause of death (if applicable)	Bio/Adoptive/Step
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____

Siblings: Please list full, half, adopted and/or step-siblings:

Name	Living?	Age	Date & cause of death (if applicable)	Full/half/step/ adopted
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____

Autobiography

Please provide a brief autobiography, beginning with your birth and including those events which you consider significant to your development. Include place of birth and where raised, family living situation, parents' employment, and any unusual family circumstances or hardship, such as parents' divorcing, financial problems, frequent moving, domestic violence, abuse or trauma. You only need write an overview and may omit details. This may be typed and attached if you prefer. Thank you.