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Intake Form

Full name: _____ SS# _____
Date of birth: _____ Gender: _____ Referred by: _____
Home Address: _____ City, zip: _____
Home Phone: _____ day/evening, OK to leave message: YES NO
Work Phone: _____ day/evening, OK to leave message: YES NO
Cell Phone: _____ day/evening, OK to leave message: YES NO
Primary Care Physician: _____ Phone: _____

Primary Insurance Information

Insurance Company: _____ Phone: _____
Address: _____
Subscriber's name: _____ Relationship to client: _____ DOB: _____
ID #: _____ Group/Plan # _____

Secondary Insurance Information

Insurance Company: _____ Phone: _____
Address: _____
Subscriber's name: _____ Relationship to client: _____
ID #: _____ Group/Plan # _____

Counselor's Notes (for office use only)

Date	Diagnosis Code	Diagnosis	Provider Signature

Reason for visit

Briefly describe your primary concerns.

Previous counseling, substance abuse services, psychiatric services, or mental health hospitalizations

Service	Year	Provider	Reason for service

Family Demographics

Relationship status (please circle all that apply): Married Divorced Separated Remarried Single
 Engaged Involved Cohabiting Widowed

Educational Level: _____ Occupation: _____
 Employer: _____ Length of Employment: _____

List any family members with a history of the following problems. Please note relationship to client.

Medical problems

Past: _____
 Present: _____

Mental health issues

Past: _____
 Present: _____

Alcohol use

Past: _____
 Present: _____

Drug use

Past: _____
 Present: _____

Physical abuse

Past: _____
 Present: _____

Sexual abuse

Past: _____
 Present: _____

Domestic Violence

Past: _____
 Present: _____

Medical History

How would you rate your general health? Excellent Good Fair Poor

When was your last comprehensive medical exam? _____

List any serious illnesses that have required hospitalization or surgery:

Are you currently taking medication? YES NO If yes, please list name, dosage, date started, and prescriber: _____

Please circle if you currently have, or have a history of, any of the following:

Allergies	Family/relationship issues	Low self-esteem	Drug/alcohol abuse
Head injury	Anxiety	Speech problems	Aggression
Defiance	Ritualistic/repetitive behaviors	Bedwetting/bowel problems	Sexualized behavior
Irritability	Fine/gross motor delays	Difficulty managing anger	Attentional difficulty
Hearing problems	Running away	Witnessed domestic violence	Suicidal thoughts/attempts
Sexual abuse	Frequent headaches	School/learning difficulty	Multiple moves
Epilepsy or seizures	Physical abuse	Sleep problems	Depressed mood
Withdrawn	Emotional abuse	Chronic illness	Panic attacks
Deaths or losses	Visual problems	Disturbing thoughts	Peer abuse/bullying
Frequent stomachaches	Mood swings	Neglect	Feelings of hopelessness
Legal issues	Extreme fears	Flashbacks	Self-injurious behavior
Migraines	Change in appetite	Hallucinations	Divorce