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Intake Form

Client's full name: _____SS#_____
Date of birth: _____ Gender: _____ Referred by: _____
Mother's name: _____ Father's name: _____
Client's 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: _____
School: _____ Phone: _____
Person Responsible for Payments:_____

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 of Parents (please circle all that apply): Married Divorced Separated Remarried Single Engaged Involved Cohabitating Widowed

Mother's Educational Level: _____Occupation: _____
Employer: _____Length of Employment: _____

Father's 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 the client's general health? Excellent Good Fair Poor
When was the client's last comprehensive medical exam? _____
List any serious illnesses that have required hospitalization or surgery:
_____
_____

Is the client currently taking medication? YES NO If yes, please list name, dosage, date started, and prescriber: _____
_____
_____

Please circle if the client currently has, or has 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