Initial Client Intake

Client name: _____ Sex: M F Birth date: _____
Address: _____
Home #: _____Work #_____Cell #: _____
Is it alright to leave messages at the above phone numbers?_____
Email address:_____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Cohabitating
Name of spouse/partner_____

If client is a minor: Parent/Legal Guardians: _____
Address (if different): _____
Home #:_____Work#:_____Cell #:_____
Is it alright to have messages at the above phone numbers?_____
Children's names and birth dates:

Others living at client's address:

Referred By:_____
Will insurance be billed for services? Y N May I email you your monthly invoices? Y N
Insurance Company_____
Type of insurance? (PPO/HMO)_____
Name of insured and date of birth_____
Policy Number_____
Authorization Number and Dates_____
Current medications prescribed or over the counter, reason for use, and name of prescribing doctor:

Have you ever sought or received psychiatric or psychological treatment of any kind?Y/N
Please circle type of previous therapy:
Child Individual Couple Family Group Inpatient
When and how long were you in treatment?_____

I understand that the following questions are very personal in nature. They are meant to help provide a general overview of possible areas to be discussed. Your reason for coming to therapy may/may not be included. Please remember that you will have time to speak in more detail. If you do not feel comfortable answering any of these questions at this time, please feel free to leave the response blank.

Do you have history of depression? Y/N Suicidal thoughts or attempts Y/N
Hospitalizations? Y/N

Is there any direct or indirect family history of mental illness? Y/N
Are you currently considering harming yourself or others? Y/N
Have you ever been emotionally, physically, or sexually abused? Y/N
Have you ever been treated for alcohol or drug dependence? Y/N
Please circle any of the following areas where you have concern:

Physical Health	Anxiety/Nervous	Mood
Eating Habits	Sleeping Habits	Ability to control anger
Suicidal Thoughts	Alcohol use	Drug use
Infidelity	Communication	Caring for an elder/dependent
Abusive Behavior (emotional, physical, sexual)		
Phase of Life	Divorce	Other:_____

Type of counseling desired:
Individual □ Child □ Family □ Couples □ Group □ Substance Abuse □

Please briefly describe your reason(s) for seeking therapy at this time. Include any other information you feel I should have.