# Client Intake Form

Name: Date Of Birth: Age:

Gender: ❑ Male ❑ Female Marital Status: ❑ M ❑ D ❑ S

Home Address:

Mailing Address:

Home Phone: Cell Phone:

Employer: Position:

Emergency Contact: Phone: Relationship:

Who referred you/How did you find me?

***Insurance Information***

Name of Insured: Gender: ❑ MALE ❑ FEMALE

Insured's Address:

Client's Relationship to Insured:

Insured's Social Security Number: Date of Birth:

Insurance Company:

Policy Number: Group Number:

*FAMILY INFORMATION*

| Name | Age | Location | Status of Emotional Relationship | Substance abuse History? Y/N | History of Mental Illness? Y/N |
|---|---|---|---|---|---|
| Parents: | | | | | |
| | | | | | |
| | | | | | |
| Siblings: | | | | | |
| | | | | | |
| | | | | | |
| Spouse/SO: | | | | | |
| | | | | | |
| | | | | | |
| Children: | | | | | |

*PAST PSYCHOTHERAPY/PSYCHIATRIC TREATMENT INCLUDING HOSPITALIZATIONS*

| Hospital/Program/Therapist | Dates of Tx | Level of Care | Reason for Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

*PAST SUBSTANCE ABUSE TREATMENT INCLUDING PARTICIPATION IN 12 STEP PROGRAMS*

| | # 1 | #2 | #3 | #4 |
|---|---|---|---|---|
| Dates of TX | | | | |
| Facility | | | | |
| Length of TX | | | | |
| Level of TX | | | | |
| Substance | | | | |

*MEDICAL*

Primary Care Physician: Phone:

Current Medical Conditions:

Current Medications Including Frequency and dosages:

Please check any of the following that may apply:

_____crying spells
_____unable to have fun
_____feelings easily hurt
_____lacking in confidence
_____constipation
_____feeling grouchy
_____always tired
_____poor appetite
_____depressed
_____trouble sleeping
_____feeling lonely
_____loss of weight
_____not enjoying things
_____suicidal thoughts
_____feeling inferior
_____loss of sexual interest
_____no one understands me
_____worried about health
_____can't concentrate
_____can't "get going"
_____feeling angry
_____don't like being alone
_____lack energy

_____fast heartbeat
_____always worried
_____frequent sweating
_____dizziness
_____shaky hands
_____stomach trouble
_____nightmares
_____feeling tense
_____cold feet and hands
_____feeling panicky
_____diarrhea
_____shy with people
_____muscle twitching
_____nausea or vomiting
_____can't make decisions
_____can't make friends
_____headaches
_____fainting spells
_____unable to relax
_____feeling fearful
_____overly sensitive
_____anxious inside
_____weight gain

_____money problems
_____relationship concerns
_____work difficulties
_____sexual problems
_____can't hold a job
_____excessive drinking
_____excessive medication use
_____excessive drug use
_____problems with children
_____problems with parents
_____poor physical health
_____fighting and quarreling
_____dislike my body
_____full of energy
_____overly ambitious
_____easily excited
_____quick tempered
_____impatient with people
_____binge eating
_____very restless
_____feel like hurting someone
_____feel like smashing things
_____excessive overeating

## *PRESENTING PROBLEM*

*Please describe why you have decided to participate in therapy:*

*What issue(s) would you like to work on in therapy?*

*How long has this been a problem (please be specific)?*

*Please list current or past problems/concerns in the areas below:*

Medical:

Interpersonal/Relationships:

Substance Abuse:

Problems with work:

Legal problems: