

INTAKE FORM

Client Name: _____

Name of parent/guardian (if under 18 years): _____

Client Birth Date: ____ / ____ / ____ Age: _____ Gender: Male Female

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

Home Address: _____

City/State/Zip _____

Contact Phone: () _____ May I leave a message? Yes No

Other Phone: () _____ May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

In case of emergency, contact _____

Relationship _____ Emergency contact phone _____

Are you taking any medication? _____ If yes, what kind? _____

Reason for medication _____

Have you ever been hospitalized for a mental illness? Yes No

If yes, Describe _____

What would you like to accomplish out of your time in therapy?

Referred by (if any): _____

Do you need a reminder for your appointments? _____ yes _____ no

If yes, preferred method of reminder _____ text _____ telephone message _____ email