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INTAKE FORM

Today's Date:_____ **Dx:_____**

Client's Name_____ DOB___/___/_____ Gender _____

Address_____ City_____ State____ Zip_____

Mailing Address _____

Cell Phone_____

Home Phone_____ Work Phone_____

Referred by_____ Highest grade/degree:_____

Employed? Yes or No **Occupation/position_____**

Relationship status: _____

If Client is a Minor:

Name of Parent or Guardian:_____ Home Phone_____
Work Phone _____
School_____Grade_____Teacher_____

Person to call in emergency:_____ Phone_____

Person to call in emergency:_____ Phone_____

Concerns that brought you to therapy: _____

Current Medical Problems_____

Current Medications _____

Primary Care Physician_____

Previous Therapists_____

Have you ever been hospitalized for psychiatric reasons? Y or N

If yes, when and where?_____

I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

Client Signature: _____ Date: _____

(Parent if Minor)