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ADULT CLIENT INTAKE FORM

Prior to or beginning therapy you will complete a client intake form. The information you provide will be helpful to me in determining your chief complaints, knowing how you would prefer to be contacted, and understanding any mental health and medical treatment history. Acquiring this information is a critical component of an overall intake process and goes hand-in-hand with informed consent which will be discussed in our intake session. If you are a couple please complete the form for both of you. Otherwise, simply complete the portion applicable to you.

GENERAL

Date			
Client #1 Name		**Client #2 Name**	
Address		Address	
City, State, Zip		City, State, Zip	
Home phone		Home phone	
Work phone		Work phone	
Cell phone		Cell phone	
E-mail		E-mail	
Age		Age	
Marital status		Marital status	
Date of birth		Date of birth	
Educational level		Educational level	
Occupation		Occupation	

Names and ages of children _____

Emergency contact information _____

Explanation of how client may be contacted by therapist _____

FINANCIAL INFORMATION

How do you intend to pay for treatment? (Cash, check, charge, Insurance)

_____

Insurance Company _____

Insurance ID # _____ Insurance Group # _____

Telephone Number _____

Secondary Insurance Company _____

Insurance ID # _____ Insurance Group # _____

Telephone Number _____

REFERRAL SOURCE

How did you locate me? _____

AREAS OF CONCERN

What issues/concerns causes you to seek treatment? Please describe.

_____

Do you have any specific goals with regard to your treatment?

_____

Do you have any particular concerns/fears with regard to treatment?

_____

PSYCHOLOGICAL HISTORY

	Client #1 Name:	Client #2 Name:
Have you ever received mental health treatment before?		
When and for how long?		
What was the focus of treatment?		
Name of treating therapist(s), address(es), & telephone number(s)		

**Authorization for release of confidential information will be needed so that any former therapist may be contacted.*

Have you ever been subjected to one or more psychological tests?		
If so, by whom? Name of person(s) administered psychological tests, address(es), telephone number(s)		

**Authorization for release of confidential information will be needed so that any former therapist may be contacted.*

	Client #1 Name:	Client #2 Name:
Have you ever been hospitalized for mental or emotional problems?		
When and for how long?		
Why were you hospitalized?		
Name of treating therapist, address, telephone number		

**Authorization for release of confidential information will be needed so that any former therapist may be contacted.*

Are you currently taking any prescription medications?		
Prescribed by whom?		
How long have you been on the medications?		
Have you ever taken any medications for a mental or emotional condition?		
When and for how long?		

**Authorization for release of confidential information will be needed so that any former therapist may be contacted.*

Have you ever attempted suicide?		
When?		
Describe the circumstances that led to that attempt		
Are you currently having any suicidal thoughts?		
Currently having homicidal thoughts?		
Please describe your childhood		
Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.		
Have you ever been a victim of a violent crime? Please describe		

MEDICAL HISTORY

	Client #1 Name:	Client #2 Name:
Have you ever been diagnosed with a serious illness? Please Describe		
Do you have any medical conditions that may affect your mental health treatment?		
Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.		
Have you ever been in a 12-step or other substance abuse program? Please describe.		
Do you smoke?		
How much?		
For how long?		
Do you drink alcohol?		
On average, how much alcohol do you consume in a week?		
Do you currently use illegal drugs? Please describe your use.		
Have you ever used illegal drugs? Please describe.		

FAMILY OF ORIGIN HISTORY

	Client #1 Name:	Client #2 Name:
Mother's name, age, living/deceased, client's age at the time of mother's death, description of relationship with mother.		
Father's name, age, living/deceased, client's age at the time of father's death, description of relationship with father.		
Names and ages of siblings.		

OTHER INFORMATION

	Client #1 Name:	Client #2 Name:
Please describe your spiritual identity/orientation.		
Please describe interests and activities.		
Are you now or have you ever been involved in a lawsuit? Please describe.		

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.