**Client Intake Form**

Address:

Cell phone:

Marital Status:

Date of birth:

Date:

 Where may I leave a message for you?

Work phone:

Home phone:

Race/Ethnicity:

Name:

 Home Cell Work

Referral source (how did you find me?):

Who do you currently live with?

Religious/spiritual orientation:

Emergency Contact Name and Number:

E-mail address:

Are you currently employed? Yes No Are you currently enrolled in school? Yes No

Any military experience? Yes No Have you been in therapy before? Yes No

*The second page of this intake form is optional. Although it would be helpful for me to have the following information completed, you have the option to leave this blank if you would prefer to discuss this during therapy sessions.*

*Medical and Psychiatric History*

Status of current health: excellent good average fair poor

Are there any other health/medical issues that you are concerned about today?

Current or past medical conditions?

Physician’s name and phone number:

Current medications:

Do you smoke? Yes No If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcohol? Yes No If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you concerned about your alcohol consumption, either now or in the past? Yes No

Do you currently or have you ever used illegal drugs or abused prescription drugs? Yes No

Does anyone in your family have a history of using illegal drugs or abusing alcohol or prescription drugs? Yes No I’m not sure

Do you ever think about or feel like hurting yourself? Yes No

Do you or anyone in your family have a history of mental illness or psychiatric hospitalization? Yes No I’m not sure

Did you or anyone in your family experience childhood physical abuse, neglect, or sexual abuse? Yes No I’m not sure

Is there anything else that you think I should know?