Intake Information

Today's Date: _____

Name: _____

Address: _____

Birthday: _____ / _____ / _____
MONTH DAY YEAR

Primary Phone Number: _____ ☐ Voice Message ☐ Text Message ☐ Voice & Text

Alternative Phone Number: _____ Email Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to Client: _____

Phone Number: _____ Alternative Number:_____

BILLING INFORMATION (if different from above or client is a minor)

Name: _____ Relationship to Client: _____

Address: _____

Birthday: _____ / _____ / _____
MONTH DAY YEAR

Phone Number: _____ Alternative Number: _____

Email: _____

Credit Card Number: _____ Expiration Date: _____

E-mail you want receipts sent to: _____

The Informed Consent for Psychotherapy and Office Policies and *Notice of Privacy Policies* must be read, understood and signed by the end of the first session. Please feel free to ask your therapist any questions you might have regarding these documents.

FOR OFFICE USE ONLY

Notice of Privacy Practices	signed: _____	date: _____
Informed Consent & Office Policies	signed: _____	date: _____

PLEASE NOTE: *You can go over information in greater detail with your therapist during your initial session.*

HEALTH INFORMATION

Your medical conditions or health issues: _____

_____

_____

Current Physician: Dr. _____ Phone: ( ) _____ - _____

Medications you take: ☐ I do not take prescription medication at this time

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Comments: _____

_____

Please describe other serious illnesses, injuries, surgery or hospitalizations: _____

_____

_____

Is there any family history of psychological, psychiatric conditions? ☐ Yes ☐ No

Is there any history of addiction in your family? ☐ Yes ☐ No

Comments: _____

_____

Please list any major medical conditions in your family: _____

_____

_____

Do you drink alcohol? ☐ Yes ☐ No What type? _____ Frequency: _____

Do you use tobacco? ☐ Yes ☐ No What type? _____ Frequency: _____

Do you use other drugs? ☐ Yes ☐ No What type? _____ Frequency: _____

RELATIONSHIP STATUS (check all that apply) ☐ married ☐ living together ☐ never married ☐ divorced ☐ separated ☐ Not currently in a relationship

Are there any relationship problems: ☐ Yes ☐ No

Comment: _____

_____

Do you have any concerns / issues with any of your children: ☐ Yes ☐ No ☐ N/A

Comment: _____

_____

Highest level of education: _____

Occupation: _____ Satisfied with job? ☐ Yes ☐ No

Have you had previous counseling or psychotherapy? ☐ Yes ☐ No

If so, with whom and when: _____

_____

Have you ever felt suicidal? ☐ Yes ☐ No Do you feel that way now? ☐ Yes ☐ No

Comments: _____

_____

Have you ever been a victim of physical or sexual abuse / assault ☐ Yes ☐ No

Are you involved in any legal proceedings? ☐ Yes ☐ No

Comments: _____

Have you ever been arrested? ☐ Yes ☐ No Have you been convicted of a crime? ☐ Yes ☐ No

Comments: _____

What are your main concerns / reasons for seeking treatment? _____

_____

_____

Did a specific event lead to this session? ☐ Yes ☐ No

Comment: _____

_____

Is there anything significant the form did not ask that you would like to add? _____

_____