

INTAKE FORM

THIS IS A GENERAL FORM USED FOR ALL CLIENTS. PLEASE FILL OUT THE APPROPRIATE AREAS.

DATE: _____

CLIENT NAME: _____ DOB: _____

PARTNER/SPOUSE NAME: _____ DOB: _____

ADDRESS: _____
CITY STATE ZIP

PHONE: PLEASE CHECK THE BEST WAY TO BE CONTACTED

HOME: _____ PARTNER/SPOUSE Wk: _____

WORK: _____ PARTNER/SPOUSE CELL: _____

CELL: _____ EMERGENCY CONTACT _____

E-MAIL: _____
WORK HOME

CLIENT EMPLOYMENT: _____

SPOUSE/PARTNER EMPLOYMENT: _____

COUPLE STATUS: ___ MARRIED/SIGNIFICANT OTHER ___ DIVORCED/RELATIONSHIP DISSOLVED ___ SINGLE
___ SEPARATED ___ WIDOWED

PLEASE LIST ANY OTHER FAMILY MEMBERS LIVING IN YOUR HOUSE.

NAME	AGE/DOB	GRADE/OCCUPATION	RELATIONSHIP
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WHAT WOULD YOU SAY IS THE PRESENTING PROBLEM? _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? WHAT MEDICATIONS HAVE YOU TAKEN IN THE PAST?

IF YOU TAKE PSYCHIATRIC DRUGS, PLEASE LIST THE NAME OF THE DOCTOR WHO PRESCRIBES YOUR DRUGS AND SIGN THE ATTACHED RELEASE.

PLEASE LIST ANY CHRONIC MEDICAL CONDITIONS

REFERRED BY: _____ MAY I THANK THEM FOR THE REFERRAL _____