

CLIENT INTAKE FORM

DATE: _____

Name: _____ DOB: _____

Social Security # _____ Gender F M Age: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Cell: _____ Email: _____

Occupation: _____ Employer: _____

Other people living in the home: (name, age, relationship)

Marital status: M S D Significant other's name: _____

Emergency contact person and Phone: _____

Have you received mental health services before? Y N

If so, with whom, when, and for how long? _____

_____ Have you ever
been treated for chemical dependency? Y N

If so, what substance, when, and for how long? _____

What, if any, medications are you taking? _____

What would you like to get from therapy? _____

Who may I thank for the referral? _____

Person responsible for the bill (if different from the client):

Name: _____ DOB: _____

Social Security # _____ Gender F M Age: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

I understand that all charges are due at the time of service, and that I am fully responsible for all charges incurred. I also understand that I am responsible to pay for missed appointments unless they are rescheduled within the same week.

Signed: _____ Date: _____