Client Intake Form

General Information:

Name (and what you prefer to be called): _____

Address: _____

_____

Phone: Home: _____

Work: _____

Cell: _____

Date of Birth: _____

Marital Status: _____

Children/ages:_____

Occupation: _____

Emergency Contact Information: _____

_____

Psychological History:

Have you ever received mental health treatment before? Y N

If yes, when and for how long? _____

What was the focus of the treatment? _____

_____

_____

Medical History

Do you have any medical conditions that may affect your mental health treatment?

_____

_____

What, if any prescription medications are you currently taking? _____

_____

How long have you been taking them? _____

Primary Care Physician: _____

Phone:_____