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Client Intake Form

Date:_____ Form Completed by: ☐Client ☐Parent ☐Guardian ☐Spouse ☐Other

Client Information

Name:_____ Referred by:_____

Date of Birth:_____ Primary Care Physician_____

Social Security Number:_____

Street Address_____

City:_____ Zip Code:_____

Phone: ☐Home_____ ☐Work_____ ☐Cell_____

(Check box next to number if it is okay to call or leave a message)

Email_____ **Preferred form of contact:** ☐Email ☐Cell ☐Home phone ☐Work phone

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other_____

Education: ☐High School ☐2-Yr College ☐Tech School ☐College Degree ☐Graduate Degree ☐Other

Employer:_____ Occupation:_____

☐Full-time ☐Part-time ☐Retired ☐Unemployed ☐Student

Emergency Contact Name:_____Relationship:_____

Emergency Contact Phone: Home_____Work_____Cell_____

If Client is a Student: Grade_____ School_____

School Counselor:_____

Please list other people residing in the home:

Name:_____ Age:_____ Relationship_____

Name:_____ Age:_____ Relationship_____

Name:_____ Age:_____ Relationship_____

Name:_____ Age:_____ Relationship_____

Name:_____ Age:_____ Relationship_____

Name:_____ Age:_____ Relationship_____

Insurance/Billing Information

***NOTE**: Please provide insurance card at first appointment.*

Person responsible for copayments, coinsurance, deductibles, and/or payment in full:

Primary Insurance Carrier:_____ Plan#_____

Subscriber Name:_____ Date of Birth:_____

Social Security Number:_____ Employer_____

Address (if different from client's) :_____City_____State____Zip____

Secondary Insurance Carrier:_____ Plan#_____

Subscriber Name:_____ Date of Birth:_____

Social Security Number:_____ Employer_____

Address (if different from client's) :_____City_____State____Zip____

Payment and Insurance Billing:

I, the undersigned, authorize the release of any medical or other information necessary to process this claim through any insurance company previously noted. I authorize payment to the providing clinician for services rendered as stated on claims submitted by him/her to my insurance company.

I also understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

Payment and Insurance Billing:

Client or Authorized Person's Signature:_____

Relationship to Client (if not client):_____

For Your Information: Your insurance company may require your therapist to exchange information with your referring and/or primary care physician. They may also require your therapist to provide copies of confidential chart notes in order to process your claim(s). You have the right to notify your therapist in writing to limit communication with your physician(s). You may also make arrangements to pay for therapy privately to avoid confidential information being released to your insurance company. Please discuss these options with your therapist.

Adult Medical History Form

Client name:_____Date Completed_____

Client DOB:_____ Form completed by:_____

Primary Care Physician:_____ City/State_____

List all doctors or medical specialists that you currently see or have seen in the last year:

1._____ 2._____

3._____ 4._____

5._____ 6._____

Date of last physical exam_____ Examiner:_____

Describe any current medical problems or recent changes in your (client's) physical condition:

_____

_____

_____

_____

Height_____ Weight_____ Recent weight gain: ☐Yes ☐No Recent weight loss: ☐Yes ☐No

Appetite: ☐Good ☐Fair ☐Poor Sleep: ☐Good ☐Fair ☐Poor

Energy level: ☐Good ☐Fair ☐Poor General health: ☐Good ☐Fair ☐Poor

List any hospitalizations:

_____

_____

_____

_____

List all medications you are taking. Include non-prescription drugs and health supplements:

1. Drug Name_____ Dosage:_____ # Per Day:_____
2. Drug Name_____ Dosage:_____ # Per Day:_____
3. Drug Name_____ Dosage:_____ # Per Day:_____
4. Drug Name_____ Dosage:_____ # Per Day:_____
5. Drug Name_____ Dosage:_____ # Per Day:_____
6. Drug Name_____ Dosage:_____ # Per Day:_____
7. Drug Name_____ Dosage:_____ # Per Day:_____
8. Drug Name_____ Dosage:_____ # Per Day:_____

Any medication allergies? ☐Yes ☐No If yes, list:_____

Check any of the following which you use now or have used in the past:

Substance	Used in past	Use How often	Is it a problem?	
Hard Liquor	☐	☐	_____	☐Yes ☐No
Beer/Wine	☐	☐	_____	☐Yes ☐No
Marijuana	☐	☐	_____	☐Yes ☐No
Speed/Meth	☐	☐	_____	☐Yes ☐No
Heroin	☐	☐	_____	☐Yes ☐No
LSD	☐	☐	_____	☐Yes ☐No
Barbiturates	☐	☐	_____	☐Yes ☐No
Cocaine	☐	☐	_____	☐Yes ☐No
Tobacco	☐	☐	_____	☐Yes ☐No
Coffee	☐	☐	_____	☐Yes ☐No
Soft Drinks	☐	☐	_____	☐Yes ☐No
Other	☐	☐	_____	☐Yes ☐No

Any additional comments on alcohol or drug use:_____

Indicate if you (the client) have had any of the following conditions:

Alcohol/drug abuse☐_____ Nervous breakdown☐_____ Anxiety/Panic☐_____

Obsessive Compulsive☐_____ ADHD☐_____ Psychiatric hospitalization☐_____

Bipolar Disorder☐_____ Schizophrenia☐_____ Depression☐_____ Dementia☐_____

Seizure Disorder☐_____ Suicide thoughts ☐_____ Suicide attempt(s) ☐_____

Have you (client) had any prior counseling or mental health treatment? ☐No ☐Yes If yes,

Date:_____ Location or therapist:_____

Reason:_____

_____

_____

_____

_____

Results:_____

_____

_____

_____

Reason for termination:_____

_____

_____

_____

Check any of the following that you (client) have had within the last six months:

Vision problems☐ Weakness in arms/legs☐ Constipation☐ Chronic pain☐

Hearing loss☐ Convulsion/seizures☐ Diarrhea☐ Back pain☐ Headaches☐

Nausea or vomiting☐ Stomach aches☐ Menstrual irregularities☐ Fainting☐ Shortness of breath☐ Unusual bleeding☐ Dizziness☐ Chest pains/tightness☐ Abnormal growth/lump☐

Head injury☐ Loss of consciousness☐ Memory loss☐ Heart Disease☐_____

Obesity☐_____ Autism☐_____ Hepatitis☐_____ Parkinson's Disease☐_____

Birth defects☐_____ High Blood Pressure☐_____ Polio☐_____ Bladder problems☐_____ Huntington's☐_____ Rheumatic Fever☐_____ Bowel problems☐_____ Hyperactivity☐_____ Stomach ulcers☐_____ Stroke☐_____

Cancer☐_____ Hypoglycemia☐_____ Cerebral Palsy☐_____ Hysterectomy☐_____

Syphilis☐_____ Chronic Fatigue☐_____ Jaundice☐_____ Thyroid Disease☐_____

Circulation problems☐_____ Kidney problems☐_____ Tuberculosis☐_____

Check any of the following that you (client) have had within the last six months (continued):

Diabetes☐_____ Learning Disability☐_____ AIDS/HIV +☐_____ Epilepsy☐_____

Leukemia☐_____ Other☐_____

List any of your blood relatives (mother, father, grandparent, sibling, etc.) who have had any of the above condition; indicate who and what:_____

_____

_____

_____

Indicate if any of your blood relatives have had the following conditions, and who:

Alcohol/drug abuse☐_____ Nervous breakdown☐_____ Anxiety/Panic☐_____

Obsessive Compulsive☐_____ ADHD☐_____ Psychiatric hospitalization☐_____

Bipolar Disorder☐_____ Schizophrenia☐_____ Depression☐_____ Dementia☐_____

Seizure Disorder☐_____ Suicide (or attempted) ☐_____

Any additional comments on your health or your family's health history: _____

_____

_____

_____

_____

Client Treatment Goals

I. Please list issues to discuss in therapy which are of primary concern to you at present:

1. _____
2. _____
3. _____
4. _____
5. _____

II. Please list any specific goals or changes you would like to accomplish:

1. _____
2. _____
3. _____
4. _____
5. _____