CLIENT INTAKE FORM

Client Information:

Name: Last ___________________________ Middle Initial _______ First ________________________________
Title: Mr. ___ Mrs.____ Ms ___ Dr. ___ **Suffix:** Jr. _____ Sr. ____ First ____ Second ____ Third ____
Sex: Male ___ Female ___ **D.O.B.:** ________ **Age:** ____ **Social Security #:** ___________________________
Address: ____________________________________ **City:** __________________ **State:** _____ **Zip:**___________
Phone: (Home) ______________________ (Cell) ______________________ (Other) ______________________
Email (optional): _________________________________ May we contact you via email? Yes _____ No _____
Relationship Status: Married ___ Divorced ___ Single___ In Relationship ___ Widowed ___ Separated ____
Employer: ___________________________________ **Job Title:** ____
Occupation: ___________________________ **Circle One:** Full-time / Part-time / Student / Retired / Unemployed

Emergency Contact: Name _______________________ Phone _________________ Relationship _____________
Please fill out the following information if another party is financially responsible for all professional services rendered to you at this office:
Name of Organization: ____ Phone: _______________________
Individual's Name: Last ______________________________ Middle Initial _____ First ________________________
Address: ____________________________________ City _______________ State _______ Zip ________________
How did you hear about our office? Work ( ) EAP ( ) Friend ( ) Dr. ( ) Psychiatrist ( ) Hospital ( )
Primary Care Physician / Medical Information: Do we have permission to contact your physician? Y ___ N ___
Name of Physician: ____ Phone: ___________________________
Address: ____________________________________ City _______________ State _______ Zip ________________
Psychiatrist: Do we have permission to contact your psychiatrist? Y ___ N ___
Name of Psychiatrist: ____ Phone: __________________________
Address: ____________________________________ City _______________ State _______ Zip ________________
By signing below, you authorize this office to contact your physician and/or your psychiatrist (as indicated above), and to inform your doctor and/or psychiatrist of your mental health therapy.
Client Signature: _______________________________________ Date: ____________________
Witness Signature: _______________________________________ Date: ____________________

List any medications you are currently taking:
Name: _____________________________________ Generic?: ____ Date began:_____ Purpose: ______________
Name: _____________________________________ Generic?: ____ Date began:_____ Purpose: ______________
Name: _____________________________________ Generic?: ____ Date began:_____ Purpose: ______________

List any past medications:
Name: _____________________________________ Generic?: ____ Date began:_____ Purpose: ______________
Name: _____________________________________ Generic?: ____ Date began:_____ Purpose: ______________
Are you allergic to any medications? Y ___ N ___ If yes, list them here:__________________________________
Medical conditions you are currently being treated for: ____
____

Insurance Policy Holder Information:
Primary Insurance Company: __________________________________ Phone: ____________________________
Address: ____________________________________ City _______________ State _______ Zip ________________
Policy Holder Name: ______________________________________ Policy Holder D.O.B.: ____________________
Social Security #: _________________________ Sex: M ( ) F ( ) Insured relationship to client: ______________
Policy Holder Phone: ____________________________ Employer: _______________________________________
Group #: _________________________________ Individual Policy #: _____________________________________

Secondary Insurance Company: __________________________________ Phone: __________________________
Address: ____________________________________ City _______________ State _______ Zip ________________
Policy Holder Name: ______________________________________ Policy Holder D.O.B.: ____________________
Social Security #: _________________________ Sex: M ( ) F ( ) Insured relationship to client: ______________
Policy Holder Phone: ____________________________ Employer: _______________________________________
Group #: _________________________________ Individual Policy #: _____________________________________