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Client Intake Form

Name: ______________________ Date: ______________________

Age: _______ Birth Date: ______________ Birth Time (if known): ____________

Birth Place: ____________ Cell Phone: (___) __________ Email: ____________

Work Phone: (___) __________ Home Phone: (___) ______________________

Address: ______________________________ City/Zip: ____________

Occupation: ______________________ Name of Firm: ____________

Work Address: ____

In case of emergency, please notify: ______________________________

Phone: (___) ____________ Relation to you: ______________________

Relationship status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Other ____________

Living arrangements:

- ☐ Alone
- ☐ With partner
- ☐ Single parent
- ☐ With roommate(s)
- ☐ With parents
- ☐ Other ____________

Please list your previous Psychotherapy and Psychiatric history (include names and dates):

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YOUR PHYSICIAN:

Your Physician's Name: ______________________ Phone: (___) __________

Last physical: Year __________ Doctor ______________ City __________

Please describe your current medical condition: ____________________________

CURRENT MEDICATIONS:

Name of Drug	Dosage	Purpose

HOSPITALIZATIONS, ACCIDENTS, SURGERIES

Year:	Event:	Outcome:

Alcolhol use:
- ☐ Never
- ☐ 1-4 times per month
- ☐ 3-4 times per week
- ☐ daily

Amount Per Use:
- ☐ 1-2 drinks per sitting
- ☐ 2-4 drinks per sitting
- ☐ 5 drinks or more

Drug Use:
- ☐ None
- ☐ Marijuana
- ☐ Sedatives
- ☐ Cocaine
- ☐ Opiates
- ☐ Nicotine
- ☐ Caffeine

How Often: ____________________

BEGINNING TREATMENT:

Who referred you to this office? ______________________________

Relationship: ______________________________