

Client Intake Information

Name _____

Date of Birth _____ Birth Place _____ Gender _____

Address _____

Street

City

State

Zip Code

Phone Home _____ Cell _____ Work _____

If I must contact you, which method do you prefer? Phone _____

Text _____ email _____

May I leave a message on your VM? Yes // No // If someone else answers your phone, may I leave a message with them? Yes // No // Please list any restrictions in regard to contacting you _____

Emergency Contact _____

Name

Relationship

Phone

Occupation/Employer _____

If student School/College _____ Grade _____

Relationship Status

Single // Married // Living together // Divorced // Widowed //

List family members/significant others with whom you are currently living:

Name	relationship	age/gender	brief description

List family/significant others who you lived with when you were a child:

Name	relationship	age/gender	brief description

Please circle any of the following in which there is a history with you or a significant person in your life:

Alcoholism	Physical Illness	Physical Abuse	Attempted suicide	Other
Drug Addiction	Mental Illness	Sexual Abuse	Suicide	_____
Eating Disorder	Recent Deaths	Emotional Abuse	Homicide	_____

Alcohol intake None // Infrequent// Daily// Have you ever had a problem controlling your drinking or drug use? When? _____

Cigarette use Yes // No //

List medical concerns that you have or have had _____

List current medications, dosage and the date you started taking the medication:

Medical Doctor _____ Psychiatrist _____

Have you had previous counseling? Yes // No // When? _____

Therapist's name _____ Reason for counseling _____

Do you feel that your goals were met at that time? Yes // No //

Have you ever been hospitalized for a psychiatric condition? If so, when and where?

Please describe your reason for seeking therapy at this time _____

Insurance Carrier _____ ID # _____

I use NorCalMedical Billing for insurance processing. If you have not contacted them yet, please call 1-888-622-1017 to provide your insurance information.

Signature Patient/Parent/Guardian

Today's date