CLIENT INTAKE INFORMATION

Today's Date:____

Client Name:____

SSN:____ Date of Birth:______________________

Address:___________________________________City/State/Zip:________________________

Phone:____ May we leave a message? **Yes** / **No**

Email address:____

Employment Status: **Full-Time** / **Part-Time** / **Self-Employed** / **Unemployed** / **Retired** / **Student**

Do you want appointment reminders? **Yes** / **No**   If yes, do you prefer **Email** / **Text** / **Voice**

Relationship Status: **Single** **Married** **Divorced** **Separated** **Living Together** **Widowed**

If married:
Spouse's Name: _____________________________Spouse's Date of Birth:_________________

Please list additional family living with you.

Name:__________________________ Sex: ____ Age: _____ Relationship:_________________

Name:__________________________ Sex: ____ Age: _____ Relationship: _________________

Name:__________________________ Sex: ____ Age: _____ Relationship: _________________

Name:__________________________ Sex: ____ Age: _____ Relationship:_________________

MEDICAL HISTORY:

Primary Care Physician Name: ______________________________ Phone:_________________

Emergency Contact Name:_________________________________ Phone:_________________

Do you have any significant health or medical issues? **Yes / No**

If YES, describe the issues and any limitations they may cause: ___________________________

____

____

List all medications you are currently taking.

Medication:_________________Dosage:_____Condition:____________Date Prescribed______

Medication:_________________Dosage:_____Condition:____________Date Prescribed______

Medication:_________________Dosage:_____Condition:____________Date Prescribed______

Medication:_________________Dosage:_____Condition:____________Date Prescribed______

Reason for Counseling Request:____

Name(s) of Previous Counselor/Therapist:____

Dates of Previous Counseling Sessions: ____

Have you noticed any changes in the following areas? (check all that apply)

___ Appetite	___Hearing	___ Speech
___Balance	___Memory	___Strength
___Bowel Movements	___Menstrual Cycle	___Thoughts
___Coordination	___Sexual Activity	___Vision
___Energy	___Sleeping Habits	___Other

Areas of Concern: (check all that apply):

___Alcohol Usage	___Fear	___Loneliness
___Anger Control	___Financial Issue	___Memory Loss
___Anxiety/ Panic	___Frustration	___Nervousness
___Career Issues	___Grief / Loss	___Nightmares
___Chronic Pain	___Headaches	___Parenting Issue
___Depression	___Health Concerns	___Relationship Issue
___Decision Making	___Insecurity	___Self-Control Issue
___Divorce / Separation	___Isolation	___Self Esteem
___Drug Usage	___Lack of Ambition	___Shyness
___Eating Problems	___Lack of Joy	___Sleeping Difficulty
___Fatigue	___Legal Issue	___Suicidal Thoughts

Have you ever abused drugs or alcohol? **Yes** / **No**

Have you ever been emotionally, physically, or sexually abused: **Yes** / **No**

All information will remain private and confidential as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).