

CLIENT INTAKE FORM

(Please Print)

CLIENT INFORMATION

Date: _____ Referred by: _____

Name: _____ Address: _____

Email address: _____

Phone: Home _____ Work _____ Cell _____

May we contact you at your: Home: ___ yes ___ no Work: ___ yes ___ no

Sex: M ___ F ___ Date of birth: _____ Age: _____

Social Security # _____ DL # _____

Marital status: _____ If married, how long? _____ Spouse name: _____

Your employer: _____ How long: _____

Job title/position: _____

Religion as a child: _____ Current Religion: _____

Signature of legally responsible adult: _____

People currently in household including yourself

Name Relationship Age Sex Education Level

1. Self _____

2. _____

3. _____

4. _____

Children living out of the home _____ Age ____
_____ Age ____
_____ Age ____
_____ Age ____

In your own words describe why you are seeking counseling:

Whom have you previously consulted about the problem(s)?

(Names & Dates)

Are you currently seeing another mental health professional?

(Names & Dates)

List any medication(s) you are currently taking

IN CASE OF EMEGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the time of each appointment. I agree to be responsible for the full payment of fees for services rendered.

X

CLIENT/GUARDIAN SIGNATURE

DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X

CLIENT/GUARDIAN SIGNATURE

DATE