

INTAKE INFORMATION

Client or Client Family Head of Household

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender M \_\_\_\_ F \_\_\_\_ prefer not to answer

Relationship Status \_\_\_\_ single \_\_\_\_ married \_\_\_\_ divorced \_\_\_\_ long-term relationship  
\_\_\_\_ widow/widower \_\_\_\_ other (describe) \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

A voicemail message for client may be left on: Home Phone \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_

A voicemail message for client may be left with:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

Email address (optional) \_\_\_\_\_

Family members residing in household:

Name	DOB	Relationship To client	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In the case of a minor client, who is (are) the legally designated party (ies) for decision making and financial responsibility?

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # \_\_\_\_\_

**Service providers working with client / family**

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_

Mental Health Provider \_\_\_\_\_ Phone \_\_\_\_\_

Case manager \_\_\_\_\_ Phone \_\_\_\_\_

Other Provider \_\_\_\_\_ Phone \_\_\_\_\_

Other Provider \_\_\_\_\_ Phone \_\_\_\_\_

Comments or additional information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information**

Do you have medical insurance that covers mental health services? \_\_\_ yes \_\_\_ no

Will you need a billing statement to give to your insurance provider? \_\_\_ yes \_\_\_ no

Provider Name \_\_\_\_\_

Provider address and phone: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Authorization Code (if required for payment of benefits) \_\_\_\_\_

**How do you identify yourself? Your family?**

Religion: \_\_\_\_\_ Race: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Culture: \_\_\_\_\_

Sexual Orientation: \_\_\_\_\_ Gender: \_\_\_\_\_

Ability/Disability: \_\_\_\_\_

Other (s): \_\_\_\_\_



**Presenting Situation**

What brings you to counseling/therapy? Please give a brief history.

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What would you like to see happen as a result of coming to counseling/therapy?

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What are your strengths (individual and family)?

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What stands in your way?

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How did you hear about my practice? \_\_\_\_\_

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