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# Client Intake Form (Adult)

| | |
|---|---|
| Date: | |
| Name: | Date of Birth: / / |
| Address: | |
| Phone Number: | May I leave a message? Yes No |
| Marital Status: | Occupation: |
| Emergency Contact: | Phone Number: |

| |
|---|
| Reason for coming to therapy: |

## Medical Insurance

| | |
|---|---|
| Insurance: | Circle one: HMO or PPO |
| ID#: | Group#: |
| Expiration date: | Phone # (back of card): |
| Primary card holder: | Primary card holder's social security #: |
| # of visits allowed a year: | Co-Pay: |
| Does your insurance accept an "out of network" provider? Yes or No | |
| Annual deductible: | |

## Medical History

| | |
|---|---|
| Primary Physician: | Phone number: |
| Date of last physical: | # of times visited in past year: |

| | |
|---|---|
| Physical symptoms you are currently experiencing: | |
| Current medical conditions: | |
| # of pregnancies: | # of children: |

| **Current Medications/Herbal Supplements** *(continue on back)* | **Dosage** |
|---|---|
| | |
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| | |
| | |

| **Date of Hospitalization** | **Reason** |
|---|---|
| | |
| | |
| | |

**Psychological History**

| | |
|---|---|
| Have you been in therapy before? | **Yes** **No** |
| When and for how long? | |
| Focus of therapy: | |
| Reason for stopping therapy? | |
| Name of previous therapist: | |
| Phone Number: | |
| Are you currently seeing a psychiatrist? | **Yes** **No** |
| Name: | |
| Phone Number: | |
| Current mental health diagnosis: | |
| Have you ever attempted suicide? | **Yes** **No** |
| # of suicide attempts: | |
| Are you currently feeling suicidal? | **Yes** **No** |
| Have you ever been physically, or sexually abused or neglected? | **Yes** **No** |
| If yes, when? | |

| | |
|---|---|
| Are you a victim of domestic violence? | **Yes** **No** |

**Family History**

Does someone in your immediate family (parent, sibling) have a history of the following:

| | | |
|---|---|---|
| Alcohol/Drug Abuse | **Yes** **No** | Family Member: |
| Depression | **Yes** **No** | Family Member: |
| Suicide Attempt | **Yes** **No** | Family Member: |
| Physical or Sexual Abuse | **Yes** **No** | Family Member: |
| Anxiety or Panic Attacks | **Yes** **No** | Family Member: |
| Domestic Violence | **Yes** **No** | Family Member: |
| Divorce | **Yes** **No** | Family Member: |

**Drug/Alcohol Use**

| | |
|---|---|
| How many drinks of alcohol do you have? | ☐ per: **day** **week** **month** |
| Are you using any drugs? **Yes** **No** | ☐ per: **day** **week** **month** |
| Which ones? | |
| Is your drug or alcohol use impairing your work? | **Yes** **No** |
| Is your drug or alcohol use impairing your relationships? | **Yes** **No** |

**Religion**

| | |
|---|---|
| What religion are you? | |
| Is this important for you in therapy? | **Yes** **No** |

| |
|---|
| What goals do you have for therapy? |

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|---|
| Anything else I should know? |