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Client Intake Form

Name: ____ Date: ___________________

Date of Birth: ________________ Age: _______ Gender: _____________________________

Address: ____

Phone: ___________________ Email: ____

Emergency Contact (name/relationship/phone number):

____

Primary care physician: ____

Reason for seeking therapy: ____

____

Mental health history (past diagnoses, hospitalizations, etc.): _________________________

____

Current medications: ____

____

Substance use (alcohol, drugs, caffeine, tobacco): ___________________________________

____

Relationship status: _________________________________

Occupation/employment: ____

Have you had therapy before? ___ Yes ___ No

If yes, with whom and when? ____

What would you like to accomplish in therapy? _____________________________________

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