

New Client Intake Form

Name _____ Today's Date _____

Social Security# _____ Birthdate _____

Address _____ City _____ Zip _____

Who Referred you? _____

Who is your primary care doctor? _____

Are you currently taking any medications? If so please list along with prescribing physician.

Have you had previous counseling/mental health services? If so please list previous providers.

Have you ever been hospitalized for psychiatric or substance abuse reasons? if so where and when?

What is your reason for seeking counseling/therapy at this time?

What do you hope to gain from therapy?

Would you like me to coordinate your care with others (doctor, school, lawyer, etc.)?

How should I contact you?

Cell phone: _____ Messages: Okay voicemail Okay other person No messages

Home phone: _____ Messages: Okay voicemail Okay other person No messages

Work phone: _____ Messages: Okay voicemail Okay other person No messages

Email: _____ (please note emails are not encrypted and therefore confidentiality can not be guaranteed)

Spouse /Significant Other / Parent /Emergency Contact Information:

Name _____ Birthdate _____ Social Security # _____

Address _____ City _____ Zip _____

Best phone number: _____ Messages: Okay voicemail Okay other person No messages