



Intake Form

NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____ CITY/ZIP _____

SOC.SEC.# _____ DRIVER'S LIC.# _____

PRIMARY LANGUAGE _____ ETHNICITY _____

HOME PHONE(_____) _____ CELL PHONE(_____) _____ EMAIL _____

NAME OF EMPLOYER _____

OCCUPATION _____

BUSINESS ADDRESS _____ CITY/ZIP _____

EDUCATION/DEGREE _____

MARITAL STATUS S M Sep D NAME & AGE OF CHILDREN _____

CURRENT LIVING SITUATION _____

DESCRIBE ANY HEALTH PROBLEMS _____

MEDICATIONS YOU TAKE & DOSAGE _____

DOCTOR'S NAME & PHONE NUMBER _____ (_____) _____

IN YOUR FAMILY, INCLUDING YOURSELF, WAS THERE:

ALCOHOLISM? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG? _____

RESOLVED? _____

SUBSTANCE ABUSE? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG? _____

RESOLVED? _____

MENTAL ILLNESS? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG? _____

RESOLVED? _____

SERIOUS ILLNESS? YES/NO FATHER/MOTHER/SIBLINGS/SELF HOW LONG? _____

RESOLVED? _____

EMERGENCY CONTACT NAME/RELATIONSHIP _____

EMERGENCY CONTACT PHONE(_____) _____

IF THE CLIENT IS A MINOR, WHO IS THE LEGAL GUARDIAN? _____

HOW DID YOU HEAR ABOUT MY SERVICES? _____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

CLIENT: _____ DATE: _____

LEGAL GUARDIAN: _____ DATE: _____