

**Intake:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of Birth: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| SSN: |  | Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| City: |  | Zip: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: |  | Cell Phone: |  |

|  |  |
| --- | --- |
| Email: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is it ok to leave a detailed Message? |  | Yes |  | No |

|  |  |  |  |
| --- | --- | --- | --- |
| Marital Status: |  | Spouse’s Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Gender: |  | Race: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Sexual Orientation: |  | Spirituality: |  |

|  |  |
| --- | --- |
| Presenting Concern |  |
|  | |
|  | |

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| --- | --- |
| Time of Onset: |  |

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| --- | --- |
| Ways you’ve attempted to address the issue |  |
|  | |
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| --- | --- |
| Other Current Stressors |  |

|  |  |
| --- | --- |
| Place of Employment: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Position: |  | Work Phone: |  |

|  |  |
| --- | --- |
| Name and ages of others living in the home: |  |
|  | |

|  |  |
| --- | --- |
| Siblings and ages: |  |

|  |  |
| --- | --- |
| Relationship Concerns |  |
|  | |

How did you find me?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Internet Search |  | Word of Mouth |  | Other |  |

|  |  |
| --- | --- |
| Previous Therapist |  |
| Dates: |  |

|  |  |
| --- | --- |
| Previous Concerns: |  |

|  |  |
| --- | --- |
| Past Traumas: |  |
|  | |
|  | |

|  |  |
| --- | --- |
| Known mental health concerns in your family: |  |

|  |  |
| --- | --- |
| Name of Present Physician: |  |
| Phone: |  |
| Physical Health Diagnosis: |  |
| Name of Psychiatrist: |  |
| Phone |  |
| Mental Health Diagnosis: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Physical Health: |  | Excellent: |  | Good: |  | Fair: |  | Poor |

|  |  |
| --- | --- |
| Last Exam Date: |  |

|  |  |
| --- | --- |
| Medications and Amount: |  |
|  | |
|  | |

|  |  |
| --- | --- |
| Insurance Carrier: |  |

|  |  |
| --- | --- |
| Name of Insured: |  |

\*\*(be sure to check with insurance panels for what information they require of your clients in order to properly complete the billing process)

**Safety Assessment**

Check for all relevant statements:

|  |  |
| --- | --- |
|  | I think about harming myself |
|  | I have physically harmed my body before |
|  | Sometimes I feel as though life is not worth living |
|  | Sometimes I think about about harming others |

|  |  |
| --- | --- |
| Person To Contact in Emergency: |  |

|  |  |
| --- | --- |
| Relationship: |  |

|  |  |
| --- | --- |
| Phone Number: |  |