

**Individual Client Intake Form**

**GENERAL INFORMATION**

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: White \_\_\_ Black\_\_\_ Hispanic\_\_\_ Asian \_\_\_ Other\_\_\_

Sex: \_\_\_ Male \_\_\_ Female

Forms Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suite/Apartment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May We Send Mail Here: \_\_\_ Yes \_\_\_ No

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave a Message Here \_\_\_ Yes \_\_\_ No

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave a Message Here \_\_\_ Yes \_\_\_ No

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave a Message Here \_\_\_ Yes \_\_\_ No

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May We Send Email Communication Here: \_\_\_ Yes \_\_\_ No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like us to have contact with your Primary Care Physician? \_\_\_ Yes \_\_\_ No

Are you currently receiving medical treatment? \_\_\_ Yes \_\_\_ No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any conditions, illnesses, surgeries, hospitalizations, traumas or related treatments you have experienced: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATIONS**

Are you currently taking any medications? \_\_\_ Yes \_\_\_No

List all current medications and dosages being taken, including those seldom used or taken only as needed:

(Use ack if necessary)

**Medication/ Dosage ­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Improves

\_\_\_Prevents

\_\_\_Controls

**Medication/Dosage** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Improves

\_\_\_Prevents

\_\_\_ Controls

**SPIRITUAL/RELIGIOUS**

How important are spiritual matters to you? (Circle One)

* Not at all
* Little
* Moderate
* Very Much

Are you affiliated with a spiritual or religious group?

* Yes
* No

**RELATIONAL INFORMATION**

Current relational status (Please check one)

* Single
* Dating
* Engaged
* Married
* Separated

Are you content with your current Status: If no, explain briefly.

* Yes
* No

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**PHYSIOLOGICAL SYMPTOMS**

Please check any of the following Physiological symptoms that apply to you presently or in the past (check past or present)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Symptoms** | **Yes** | **No** | **Current** | **Past** |
| Sleep Trouble |  |  |  |  |
| Weakness |  |  |  |  |
| Rapid Heart Rate |  |  |  |  |
| Intestinal Troubles |  |  |  |  |
| Stomach Troubles |  |  |  |  |
| Change in Appetite |  |  |  |  |
| Pain |  |  |  |  |
| See/Hearing Things |  |  |  |  |
| Chest Pain |  |  |  |  |
| Dizziness |  |  |  |  |
| Visual Troubles |  |  |  |  |
| Speech Problems |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Headaches |  |  |  |  |
| Trouble Relaxing |  |  |  |  |
| Tension |  |  |  |  |
| Trembling |  |  |  |  |
| Difficulty Breathing |  |  |  |  |
| Tiredness |  |  |  |  |

**CURRENT STATUS**

Please check any of the Following Problems which pertain to your child and /or your family (check past or present)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Symptoms** | **Yes** | **No** | **Current** | **Past** |
| Stress |  |  |  |  |
| Loss of Self Control |  |  |  |  |
| Disorganized Thoughts |  |  |  |  |
| Loss of Memory |  |  |  |  |
| Paranoia |  |  |  |  |
| Hyperactive |  |  |  |  |
| Mood Shifts |  |  |  |  |
| Dissociative States |  |  |  |  |
| Racing Thoughts |  |  |  |  |
| Trouble with Job |  |  |  |  |
| Loss of Ambition |  |  |  |  |
| Loneliness |  |  |  |  |
| Problems with Children |  |  |  |  |
| Anger Problems |  |  |  |  |
| Communication Issues |  |  |  |  |
| Issues with Friends |  |  |  |  |
| Parental Problems |  |  |  |  |
| Marital Problems |  |  |  |  |
| Anxiety |  |  |  |  |
| Depression |  |  |  |  |
| Guilt |  |  |  |  |
| Unwanted Thoughts |  |  |  |  |
| Grief |  |  |  |  |
| Emotional Abuse |  |  |  |  |
| Sexual Abuse |  |  |  |  |
| Physical Abuse |  |  |  |  |
| Verbal Abuse |  |  |  |  |
| Shyness |  |  |  |  |
| Fears/Phobias |  |  |  |  |
| Inferiority |  |  |  |  |
| Bad Dreams |  |  |  |  |
| Terminal Illness |  |  |  |  |
| Legal Issues |  |  |  |  |
| Issues with Changes in Life |  |  |  |  |
| Compulsivity |  |  |  |  |
| Irritability |  |  |  |  |
| Disorientation |  |  |  |  |
| Nervousness |  |  |  |  |
| Hopelessness |  |  |  |  |
| Sexual Addiction |  |  |  |  |
| Cyber Addiction |  |  |  |  |
| Difficulty with Gambling |  |  |  |  |
| Pregnancy |  |  |  |  |
| Abortion |  |  |  |  |
| Recent Death |  |  |  |  |
| Trauma |  |  |  |  |
| Crying Spells |  |  |  |  |
| Suicidal Thoughts/Attempts |  |  |  |  |
| Self-Harm |  |  |  |  |
| Panic Attacks |  |  |  |  |
| Defiance |  |  |  |  |
| Anti-Social Behaviors |  |  |  |  |
| Attachment Issues |  |  |  |  |
| Judgement Errors |  |  |  |  |
| Problems with Authority |  |  |  |  |
| Risk Taking Behavior |  |  |  |  |
| Anti-Social Behavior |  |  |  |  |
| Eating Disorder |  |  |  |  |
| Alcohol Use |  |  |  |  |
| Drug Use |  |  |  |  |
| Paranoia |  |  |  |  |
| Aggressiveness |  |  |  |  |
| Financial Issues |  |  |  |  |
| Martial Issues |  |  |  |  |
|  |  |  |  |  |

***TERMS OF SERVICE***

*I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for the service.*

*Name of person responsible for payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of person responsible for payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_*