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CLIENT INTAKE FORM

Client Information:

Client Name: _____ Date of birth: _____
Address: _____
City: _____ State: _____ Zip: _____

Home phone: _____
Cell phone: _____
Work phone: _____
Number to receive text messages: _____
E-mail address: _____

Employer: _____ Date began: _____
Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Referred by: _____
May I contact this person to thank them? ____ Yes ____ No

Reason for seeking therapy: _____
_____
_____

Who lives in your home besides yourself?

Name	Date of Birth	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical /Mental health history:

Primary Physician: _____ Medical Conditions: _____

Psychiatrist Name: _____ Phone number: _____
Current Medication: _____ Date began: _____
_____ Date began: _____
_____ Date began: _____
Previous Counseling: _____ Dates: _____

_____ Dates: _____
_____ Dates: _____
Psychiatric Hospitalizations: _____ Dates: _____
Detox/Rehab: _____ Dates: _____

Religious Background: Denomination: _____ Participation: _____

Emergency contact information:
Name: _____ Relationship to client: _____
Address: _____
City: _____ State: _____ Zip: _____

Home phone: _____
Cell phone: _____
Work phone: _____

Responsible party:
If you are the parent or legal guardian of a client who is under the age of 18, please complete the following with your information (if different than client).

If you are over the age of 18, please proceed to the next section of this form.

Name of parent or legal guardian: _____ Date of birth: _____
Address: _____
City: _____ State: _____ Zip: _____

Home phone: _____
Cell phone: _____
Work phone: _____

Form of payment:
The following forms of payment are accepted: cash, check, Visa, MasterCard and Discover. Payment is due at the time services are rendered.

If you choose to use a credit or debit card, the information provided below will be securely stored in your clinical file and may be updated upon request at any time. Email automated statements are available by request.

Account holder information:
Please indicate the name and address associated with your credit card or bank account.
Name: _____
Address: _____

Account information:
Card type: Visa MasterCard Discover CVV: _____
Card number: _____ Expiration date: _____

I certify the information provided above is accurate to the best of my knowledge. I also authorize any session fees to be deducted from the form of payment designated on this form. I agree to update any changes in information as soon as possible.

Cardholder signature **Date**