CLIENT INITIAL INTAKE INFORMATION

All information provided is privacy protected by this office.

Legal Name: Preferred Name:

DOB: Age: Gender Identity:

Primary Relationship Status:

___ Never Married ___ Domestic Partnership ___ Married

___ Separated ___ Divorced ___ Widowed

Address:

Employer: Occupation:

Preferred Phone: ( ) _____

May we leave a voice message? ___ Yes ___ No
May we leave a text message? ___ Yes ___ No

Email Address:

(Please note that email is not considered privacy protected.)

Please specify your preferred method of communication with us:

Emergency Contact Person:

Relationship:
Phone:

Whom may we thank for referring you?

State briefly what brings you to therapy, issues you want to address, and/or goals to be accomplished:

Previous therapy or psychiatric services:

HEALTH INFORMATION

Please list any current health problems you are experiencing:

Please list all current prescription medications:

Are you currently experiencing increased periods of sadness, grief, or hopelessness? If so, please describe briefly.

Are you currently experiencing episodes of significant anxiety or panic which interfere with daily life? If so, please describe briefly.

Please describe any changes in sleep patterns or appetite.

Alcohol use per week: Type of alcohol:

Please list any current recreational drug use:

Please list any history of recreational drug use:

Have you experienced any significant life changes/transitions over the past year? Please describe.

Briefly describe one or two of your strengths.

Briefly describe one or two of your ongoing challenges or difficulties.

I understand that I am responsible for full payment at the time of service.
I understand that I will be charged for no-show appointments or cancellations less than 24 hr notice.
I certify that the above information is accurate to the best of my knowledge.
I acknowledge that I have received a copy of HIPAA privacy practices.

Signature of Client _____ Date: _____/_____/_____