

## CLIENT INFORMATION/INTAKE FORM

Name \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Relationship Status \_\_\_\_\_ Name Of Partner \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Subscriber \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Certificate/ID# \_\_\_\_\_ Group \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Prior Psych Treatment  Yes  No Name of Provider \_\_\_\_\_

Phone \_\_\_\_\_

Current Medication \_\_\_\_\_ For \_\_\_\_\_

### Family Information:

Mother's Name \_\_\_\_\_ Living  Yes  No Age \_\_\_\_\_

Health \_\_\_\_\_

Father's Name \_\_\_\_\_ Living  Yes/  No Age \_\_\_\_\_

Health \_\_\_\_\_

Siblings: (Names And Ages) \_\_\_\_\_

Children: (Names And Ages) \_\_\_\_\_

Brief Reason for Seeking Treatment \_\_\_\_\_

Therapeutic sessions are 45-50 minutes in length. If you have to cancel an appointment, 24-hour notice is required. If this does not occur, you are responsible for payment of the missed session. Unless otherwise arranged, payment for each appointment is due at the end of the session.

I understand that this record is confidential, and that no information contained will be released to anyone without my signed consent with the exception that the law does release the therapist from confidentiality in cases where the patient is deemed dangerous to self or other(s).

I, \_\_\_\_\_, ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL THE INFORMATION AND POLICIES THAT HAVE BEEN PRESENTED IN THIS INTAKE FORM.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE

LEGAL GUARDIAN (If Patient is a Minor) \_\_\_\_\_