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INTAKE INFORMATION

Today's Date_____

Name_____

Date of Birth_____ **Age**_____

Address_____

City:_____

State_____**Zip:**_____

Gender: M F

Home Phone_____

May I leave a message at this number? Y N

Work Phone_____

May I leave a message at this number? Y N

Cell Phone_____

May I leave a message at this number? Y N

Emergency Contact (Name)_____**Relation**_____

Single:_____**Partnered:**_____**Married:**_____**Divored:**_____**Other:**_____

Names and ages of children:_____

With whom do you currently live?

_____

Employer:_____
_____

Occupation:_____

Social Security #:_____

Insurance company:_____

Name of insured:_____

Policy number:_____

Group Number:_____

Physician's name:_____

Medications:_____
_____

Chronic medical conditions:_____
_____

Allergies/adverse reactions:_____
_____

Do you smoke cigarettes? Y N If yes, how much_____

Do you drink alcohol? Y N How often do you drink?
_____

How much:_____

Ever been arrested for DWI? Y N If yes, when:___

Previous therapy/treatment history? Y N

Names of therapists/treatment facilities
When/length of treatment

_____
_____

_____
_____

_____
_____

How did you get my name----------

Name of person who referred you----------

Briefly, what brings you here today?

_____
_____

Current stressors in your life:_____

_____
_____

Your strengths:_____
_____

On whom do you rely for emotional support?
_____

CHECK PROBLEMS THAT APPLY TO YOU

Relationship issues

Health related issues

Alcohol or drug misuse/abuse or dependence

Depression

Anxiety

Bi-Polar Disorder

Suicidal Thoughts

Life transitions (Birth of child, retirement, children leaving home, death of spouse, divorce)

Death of a loved one including pets

Work/job related stress

Issues with aging parents

Problems with children

Domestic abuse/violence

Financial stress

Eating Disorders