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CLIENT INTAKE EVAULATION

1. IDENTIFYING INFORMATION

Client's Name:	Today's Date:	Referred By:
Partner's name if being seen as a couple:		

Gender: M ☐ F ☐ Age: _____ Birth Date: _____ (mm/dd/yyyy) Marital Status: _____

Home address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone: _____ (home) _____ client (work) _____ partner (work)

May we leave messages for your at home? Yes ☐ No ☐ May we leave messages for your at work? Yes ☐ No ☐

Others living in the home: _____ (name, birthdate, relationship to client) _____ (name, birthdate, relationship to client)

_____ (name, birthdate, relationship to client) _____ (name, birthdate, relationship to client) _____ (name, birthdate, relationship to client

Education (self): _____ Partner: _____

Occupation (self): _____ Partner: _____

Client's Employer: _____

Social Security (ID) Number (self): _____ Partner: _____

Emergency contact: _____ Phone: _____

Insurance Information

Name of insured: _____ Insured date of birth: _____ (mm/dd/yyyy)

Address of insured person: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Relationship of client to insured person: _____

Employer of insured person: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Insurance Identification Number: _____ Group Number: _____

Secondary insurance: _____ Phone: _____

Name of secondary insured: _____ Date of Birth: _____ (mm/dd/yyyy)

Secondary company address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Secondary identification number: _____ Group number: _____

PATIENT OR AUTHORIZED PERON'S SIGNATURE: I authorizer the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provide of services

_____

Signature (Insured) Date

Client Name: _____

2. PRESENTING PROBLEM

Describe the problem that brought you here today:

Check any of the symptoms that you are having:				(This space reserved for additional comments by clinician)
Depression		Feeling hopeless		
Extreme sadness		Feeling tearful		
Trouble concentrating		Change in sleeping habits		
Memory problems		Lack of energy		
Change in eating habits		Weight changes		
Feeling of extreme happiness		Change in sexual interest or function		
Trouble performing your job		Problems getting along with friends or family		
Lack of enjoyment of usual activities		Feeling stressed		
Self-esteem problems		Easily irritated		
Perfectionism		Feeling guilty		
Obsessions or compulsions		Feeling nervous		
Feeling fearful		Sudden feelings of panic		
Physical complaints of pain		Muscle tension		
Problems with anger		Acting violently		
Thoughts about hurting yourself or others		Thoughts about killing yourself or others		

Continue on other side

3. HAVE YOU EVER BEEN IN COUNSELING BEFORE? **Yes** ☐ **No** ☐

If you have been in counseling before, please describe it below. Start with most recent time first.

A. When did you have counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	
B. When did you have counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	

4. MEDICAL INFORMATION

Have you seen a doctor within the past year?	Yes ☐ No ☐
Why have you seen a doctor?	
Who is your doctor?	Phone:
Are you taking any kind of medications? (prescription or over –the counter)?	Yes ☐ No ☐
Please list any medications that you are taking:	
Do you have allergies to anything?	Yes ☐ No ☐
Describe any allergy problems that you may have:	

5. SUBTANCE USE HISTORY

Do you use/have you used tobacco (any form?)	Current ☐	Past ☐	No ☐
Do you use/have you used alcohol?	Current ☐	Past ☐	No ☐
Do you use/have you used caffeine (any form including cola drinks)?	Current ☐	Past ☐	No ☐
Do you use/have you used recreational drugs?	Current ☐	Past ☐	No ☐