

Client Intake Information

CLIENT INFORMATION

Today's Date: _____

Name: _____

Address: _____ / _____ CITY _____ STATE _____ ZIP CODE _____

Birthdate: _____ / _____ / _____
MONTH DAY YEAR

Primary Phone Number: Voice Message Text Message Voice & Text _____

Alternative Phone Number: _____ Email Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to Client: _____

Phone Number: _____ Alternative Number: _____

DOB: _____ I give permission to contact this person _____ Initial here

INSURANCE POLICY HOLDER

BILLING INFORMATION (if different from above or client is a minor)

Name: _____ Relationship to Client: _____

Address: _____ / _____ CITY _____ STATE _____ ZIP CODE _____

Birthdate: _____ / _____ / _____ Phone Number: _____
MONTH DAY YEAR

Alternative Number: _____

Email: _____

E-mail you want receipts sent to: _____

| FOR OFFICE USE ONLY | |
|---------------------|-------|
| Therapist: | _____ |
| Account#: | _____ |
| Diagnosis: | _____ |
| _____ | _____ |

The Informed Consent for Psychotherapy and Office Policies and Notice of Privacy Policies must be read, understood, and signed by the end of the first session. Please feel free to ask your therapist any questions you might have regarding these documents.

FOR OFFICE USE ONLY

Notice of Privacy Practices Initial: _____ date: _____

Informed Consent & Office Policies Initial: _____ date: _____

Health Insurance Claim Form Initial: _____ date: _____ N/A

PLEASE NOTE: You can go over information in greater detail with your therapist during your initial session.

Natalie P. Townsend, CMHC

HEALTH INFORMATION

Your medical conditions or health issues: _____

Current Physician: Dr. _____ Phone: () _____ - _____

Medications you take: I do not take prescription medication at this time

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Comments: _____

Please describe other serious illnesses, injuries, surgery or hospitalizations: _____

Is there any family history of psychological or psychiatric conditions? Yes No

Is there any family history of addiction? Yes No

Comments: _____

Please list any major medical conditions in your family: _____

Do you drink alcohol? Yes No Type: _____ Frequency: _____

Do you use tobacco? Yes No Type: _____ Frequency: _____

Do you use other drugs? Yes No Type: _____ Frequency: _____

RELATIONSHIP STATUS (check all that apply)

married living together never married divorced separated not currently in a relationship

Are there any relationship problems: Yes No Comment: _____

Do you have any concerns / issues with any of your children: Yes No N/A

Comments: _____

Highest level of education: _____

Occupation: _____ Satisfied with job? Yes No

Have you had previous counseling or psychotherapy? Yes No

If so, with whom and when: _____

Have you ever felt suicidal? Yes No Do you feel that way now? Yes No

Comments: _____

Have you ever been a victim of physical or sexual abuse / assault Yes No

Are you involved in any legal proceedings? Yes No

Comments: _____

Have you ever been arrested? Yes No Have you been convicted of a crime? Yes No

Comments: _____

What are your main concerns / reasons for seeking treatment? _____

Did a specific event lead to this session? Yes No

Comments: _____

Is there anything significant the form did not ask that you would like to add?

Comments: _____