



Client Intake

NAME (First/Last/I): _____ DOB: _____ Age: _____
Unmarried Married Separated Divorced Widowed Minor

Address _____ City _____ St _____ Zip _____

Home () - Work () - Cell () -

Please indicate your phone preference / restrictions: _____

Soc. Sec. # _____ Dr. Lic. # _____

EMERGENCY CONTACT (or legal guardian's information, if applicable)

(First/Last/I): _____ DOB: _____ Age: _____ Sex: _____

Address _____ City _____ St _____ Zip _____

Home () - Work () - Cell () -

INSURANCE INFORMATION

Member ID # _____ / Group # _____

Insurance Company and Plan Name: _____

Employer _____

Referring Physician (if required): _____

Primary Insured's Name (if different than client): _____

Primary Insured's DOB: _____

Address (if different than above): _____

Phone: _____

Employer _____

HOW DID YOU HEAR ABOUT THIS SERVICE? (please circle below):

Other Provider (first/last name): _____

Is it ok for me to thank this person/organization? Y N

Advertisement? if so, where? _____

Other? _____

BIOPSYCHOSOCIAL HISTORY

Why are you seeking counseling now? Briefly include emotional, mental, health, and/or spiritual concerns: _____

Have you ever seen a counselor in the past? Yes / No

Do you currently see another counselor? Yes / No If yes, please provide his/her name:

How would you describe your general state of health? (Circle)

Excellent Good Fair Poor



Please list any health conditions/ illnesses that you believe are relevant to your counseling:

Please list all current medication (prescription, otc, vitamins, herbs, homeopathic, etc.):

Who monitors your medication? _____

Have you ever been hospitalized for mental health issues or detox? Yes / No If yes, why?

Are you having suicidal thoughts? _____

Have you ever attempted suicide? _____

Do any of your family members have mental health issues? Yes / No If yes, what?

Do you have any dietary restrictions (religious, political, doctor advised, vegan, etc.)?

Meals: How many do you eat per day? _____

Alcohol: How much and how often? _____

Caffeine: How much and how often? _____

Recreational drugs: What type(s) and how often? _____

Sleep: How many hours per night on average? _____

Education Level: _____ Occupation: _____

Hobbies: _____

Cultural / Religious Identification: _____

Do you exercise regularly? Yes / No Frequency? _____

Are you often exposed to hazards (work, home, hobbies, etc.)? Please describe:

Do you have children? Yes / No Ages? _____

Please describe who lives in your home: _____

How stressful is your home, work or other aspects of your life? _____

How do you manage stress? _____

Is there anything that you feel that is important that has not been covered?
