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Initial Intake Information

Client Name:_____ **Phone (h)**:_____
(w):_____
(c):_____
Address: _____
_____ **Email:**_____

DOB: _____ **Age:**_____ **Gender:** M F T **Sexual Orientation:** _____

Parent I: _____
(Name, address, phone, custody)
Parent II: _____
(Name, address, phone, custody)

Employer and Employer Address:_____
_____

Insurance:_____ **ID#:** _____
Group #: _____

Subscriber (if different from above)**:** _____

Emergency Contact: _____
(Name, phone)
Physician: _____
(Name, address, phone)

Date of Last Physical Exam: _____
Medical Conditions: _____
Medications: _____
(Name, Dosage, Prescribing physician)
Allergies: _____
Past Hospitalizations: _____
_____

Current/past suicidal/homicidal thoughts/attempts (in detail):
_____
_____
_____

Family History:
Any self/family history/current of the following:

Substance Use/Abuse: **Y N**
Neglect: **Y N**
Sexual Abuse: **Y N**
Medical Illness: **Y N**
Legal Involvement: **Y N**
Physical/Emotional Abuse: **Y N**
Domestic Violence: **Y N**
Suicides: **Y N**
Major emotional/psychiatric illness: **Y N**
Learning Disabilities: **Y N**