CLIENT INTAKE FORM

Date: _____

Name

_____

Gender _____

Address _____ City_____

Zip_____

Age and D.O.B. _____

Phone: Home _____Cell _____Work _____

Okay to leave voice mail message? Y/N On which phone? H/C/W

E-mail_____

HEALTH INSURANCE INFORMATION
If we are billing your insurance, please fill in the following information from your insurance card, and bring your card with you to our first session:

PRIMARY INSURANCE:
Insurance Company: _____
Insurance Company Address: _____
_____
Insurance Company Phone #: _____
Client ID#: _____Group/Plan #: _____
Policy Holder Name: _____
Date of Birth: _____ SS#: _____
Relationship to you: _____

SECONDARY INSURANCE:
Insurance Company: _____
Insurance Company Address: _____
_____
Insurance Company Phone #: _____
Client ID#: _____Group/Plan #: _____
Policy Holder Name: _____
Date of Birth: _____ SS#: _____
Relationship to you: _____

Employment status/occupation_____

Any financial problems at present?_____

Relationship Status _____

Others living with you _____

Children & their ages _____

Referred By _____

Primary Care Provider _____

ER nearest to your location:_____

Emergency Contact_____

Emergency Contact Phone number _____

Reason For Psychotherapy

_____

_____

Previous Psychotherapy or Treatment

_____

_____

Current Medications/Supplements

_____

Eating Habits/Diet_____

Exercise_____

Food allergies _____

Amount Daily Intake: Water _____ **Caffeine** _____

Do you use alcohol? Y/N Frequency?

_____

Tobacco? Y/N Frequency?

_____

Recreational Drugs (please specify type and frequency of use)_____

History of substance/alcohol abuse? Y/N If yes, please describe:

_____

_____

Have you ever been in treatment for substance/alcohol abuse? Y/N

Familial history of substance/alcohol abuse? If yes, please describe:

_____

_____

Have you ever been hospitalized for psychiatric reasons? Y/N If yes, please give dates and reason for hospitalization:

_____

_____

Have you ever attempted suicide? Y/N When? _____

Injuries/Surgeries and Dates:

_____

For items below please mark "C" for current and "P" for past.

EMOTION/PSYCH	DIGESTION	MUSCULAR-SKELETAL	RESPIRATORY
Depression	Acid Reflux	Arthritis	Asthma
Eating Disorder	Constipation	Back Pain	Bronchitis
Substance Abuse	Diabetes	Carpal Tunnel	Emphysema
	Diarrhea		Pneumonia
REPRODUCTIVE	Hypoglycemia	**NEUROLOGICAL**	Tuberculosis
Birth Control	IBS	Epilepsy	
Cesarean/VBAC	Liver Disorder	Dizziness	**AUTO-IMMUNE**
Endometriosis	Ulcers	Insomnia	AIDS/HIV
Pregnancies #		Migraines	Allergies
Abortion #	**URINARY**		Cancer (type)
Miscarriage #	Bladder Infection	**CARDIOVASCULAR**	Fatigue
STD (type)	Kidney Stones	Angina	Fever (chronic)
		Arrhythmia	Fibromyalgia
ENDOCRINE	**EARS/NOSE/THROAT**	Heart Attack	Fungal Infections
Adrenal Insuf.	Earaches	Heart Failure	Herpes
Hyperthyroid	Headaches	Hypertension	Mononucleosis
Hypothyroid	Jaw Pain/TMJ	Stroke	Skin Disorder

List any joyous and/or traumatic events that occurred in your life, and when they happened.

_____

_____

What are your goals/expectations from psychotherapy in the short and long term?

_____

_____

Would you describe yourself as spiritual? Y/N If yes, what does that mean to you?

_____

_____

Is there anything else that you feel is important to mention?

_____