CLIENT INTAKE INFORMATION FORM

Today's Date:________________

GENERAL INFORMATION- Please print

Name: Last ________________________________ First:_________________________MI:______

Mailing Address:____ City:_______________

State:______Zip:__________

Responsible Party (if different than above)

Name: Last_________________________________

First:_________________________________MI:__________

Mailing Address:___________________________________ City:_____________State:_______ Zip:_______

Preferred Leave msg?

Home Phone_______________ O O Y O N Email:______________________________________

Work Phone_______________ O O Y O N

Cell Phone________________ O O Y O N

DOB:____/_____/______ Age:______ O Male O Female SSN:________-_________-________

Place of Employment:__________________________________

Job Title: _____________________________________

Emergency Contact:___________________ Phone #:______________________

Relationship______________________

Marital Status: O Single O Engaged O Married/Partnered O Separated O Divorced O Widowed

Spouse/Partner's Name:___________________________________

# of years together:___________________________

Religious/DenominationalPreference:____

Referred by:____

May we thank the person? ___ Yes ___NO

CONCERNS

Why are you seeking help now?

____

____

____

What would you like to see happen as a result of coaching or psychotherapy?

____

____

____

MEDICAL & PSYCHOLOGICAL HISTORY

Physician's Name:____________________________ Physician's Phone:___________________

Date of last physical:__________________

List physical illnesses or symptoms

____

____

____

Current Medication	Dosage	Frequency	Prescribing MD

Psychiatrist's Name:____________________ Psychiatrist's Phone:___________________________

Have you ever had counseling or psychotherapy in the past? O Yes O No

If yes, when?_____________________________ Where?______________________________

Have you ever been hospitalized for a psychiatric illness? O Yes O No

If yes, when?_____________________________ Where?______________________________

Check which of the following you use, and note the amount and frequency of each:
O Caffeine:____________ O Tobacco:______________ O Coffee___________________
O Sodas:____________ O Porn_________________ O Pills_________________
O Alcohol:____________ O Marjiuana:____________O Cocaine, Crack:______________
O LSD: _______________O Inhalants:_______________O Other:____________________

Have you been concerned or ever felt guilty about your use of drugs/alcohol OYes ONo
Has anyone ever expressed concern about your use of drugs/alcohol? OYes Ono
If yes, who? ____________

Have you ever had a DUI? O Yes O No If yes, how many______
When?________________________________

Have you ever felt annoyed by criticism of your use of drugs/alcohol? O Yes O No

Have you ever needed drugs/alcohol to get going in the morning, to function at work or social events, or to cope withdrawal symptoms? O Yes O No