New or Returning Client Intake

(To be completed again after a 6 month lapse in treatment)

DATE_____

PATIENT NAME	ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS
ok to contact/leave message: Y N	ok to contact/leave message: Y N	ok to contact/leave message: Y N	

GENDER	SOCIAL SECURITY #	DATE OF BIRTH
FEMALE MALE		

OCCUPATION	EMPLOYER	STUDENT
		Y N

Who May We Contact In An Emergency

NAME	NAME
ADDRESS	ADDRESS
PHONE	PHONE
RELATIONSHIP	RELATIONSHIP

INSURANCE INFORMATION

Primary Insurance	Subscriber ID	Group #	Primary Ins Phone #

Primary Insured's Name	Primary Insured Employer	Primary Insured SSN	Primary Insured DOB

Secondary Insurance	Subscriber ID	Group #	Secondary Ins Phone #

Secondary Insured's Name	Secondary Insured Employer	Secondary Insured SSN	Secondary Insured DOB

What is happening in your life which resulted in this appointment? _____

_____

_____

What would you like to see accomplished in therapy? _____

_____

_____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU). Please use the following numbers to rate the severity: 1=NONE; 2=MILD; 3=MODERATE; 4=SEVERE

__Feeling sad/blue	__Low Energy	__Low Self-Esteem
__Poor Concentration	__Hopelessness	__Worthlessness
__Guilt	__Sleep Disturbance (more/less)	__Appetite Disturbance (more/less)
__Feeling everything is an effort	__Greif/Loss	__Isolation/Social Withdrawal
__Anxiety/panic	__Anger	__Family Problems
__Work Problems	__Relationship Problems	__Pain Problems
__Financial Problems	__School Problems	__Legal Issues
__Martial Conflict	__Substance Abuse Problems	__Alcohol Problems

Previous outpatient therapy? No Yes Reason:
Name of therapist: Date(s):

List any psychiatric medication you are currently taking:

List any medical problems you may have:

Name of Primary Care physician

Address

Phone #