CLIENT INTAKE INFORMATION

Date: _____ Date of Birth: _____

First Name Middle Name Last Name

_____

CONTACT INFORMATION

Phone Number: _____ OK to call: ___ OK to leave message: ___

Alternative Number: _____ OK to call: ___ OK to leave message: ___

Street Address

_____

City State Zip Code

_____

EMPLOYMENT INFORMATION

Occupation Name of company

_____

Work Number _____ OK to call ___ OK to leave message ___

EMERGENCY CONTACT INFORMATON

Emergency Contact Name Relationship to you

_____

Emergency Contact Phone Number(s): _____

HEALTH CARE INFORMATION

Health Care Provider's Name(s)/Phone Number(s)

_____

Current Medications

_____

Have you seen a therapist in the past? _____

Are you currently seeing another counselor/therapist or a psychiatrist? If so, list names and phone numbers

_____

SYMPTOM CHECKLIST

Are you experiencing any marked changes or concerns in the following areas?
(Circle all that apply)

Appetite	Sleep
Breathing	Headaches
Numbness	Dizziness
Faintness	Sex
Stomach	Weight loss or gain
Alertness	Concentration
Memory	Decision making
Nightmares	Anxiety
Depression	Sadness
Irritability	Agitation
Conflict in current relationship	Pain