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INTAKE FORM

PLEASE FILL IN THE INFORMATION BELOW AND BRING IT WITH YOU TO YOUR FIRST SESSION. PLEASE NOTE: INFORMATION PROVIDED ON THIS FORM IS PROTECTED AND CONFIDENTIAL INFORMATION.

Client Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Gender: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

MENTAL HEALTH HISTORY AND CURRENT SYMPTOMS

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner/clinic: _____

Are you currently taking any prescription medication?
□ No □ Yes, please list:

_____
_____

What brings you or your child into therapy at this time (what are your concerns)?

_____
_____
_____