INTAKE FORM

Client Name: _____ Date of Birth: _____

Sex:_____ Highest Grade Level Achieved _____: Occupation_____

Address: _____

_____

Home Phone: _____ Cell Phone: _____ May We Text? Yes/No (_____initial)

Email Address: _____ May We Email? Yes/No (_____initial)

Person/Agency Responsible for Payment: _____

Intake/Interview Date: _____ Intake Therapist: _____

Reason for Requesting Services: _____

_____

_____

Diagnosis: _____ ICD Code: _____

Medicine: _____

_____

Referral Source: _____phone_____

Other Providers: _____

Family Information:

Name	Age	Relationship	Occupation/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Additional names continued on back of form)

Treatment Goals:

1._____

2._____

3._____

Revised Treatment Goals: _____

_____

_____

_____

_____