Client Intake Form

Name:			Date of Bi	rth:		
Mailing Address:						
City:		State: _		Zip: _		
Email:						
Phone:		:	Permission	to leave	message?	Yes/No
How did you find me	?					
Social Media	Referred by anot	ther profes	sional:			
Web Search	Referred by frie	end/family n	member:			
Psychology Today			Other:			
Theravive						
Goals for counselin	g:					
Previous counseling	experience and l	Location:				

Any questions for first session?					
			_		
Primary Medical Provider:					
			_		
Office Address:					
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CILY	State.	Zip:	-		
Phone:		Date of last exam:	_		
Medical Diagnoses:					
Surgeries or hospitalizations (p dates and hospital name:	lease include	psychiatric hospitalizations) with			
-			_		
			_		
Current medications (please incl	ude dose, fre	quency, and prescribing physician):			
Allergies:			_		
Averages hours or steep/hight: _		Water/day:	-		
Meals/day:	Caffeine:	Exercise:			
Alcoholic drinks/week:	Tobacco:	Tobacco:			
History or Current illegal drug					
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