Adult Client Intake Form

Date__________________

Client Name:____
Last First MI

DOB:__________________

Gender assigned at birth:__________ Preferred Pronouns:______________

Address:____
Street City ST Zip

County:___________ Phone: (H)________________________ Msg Ok_________

(Cell)________________________

Education: # Years:_____ Highest Degree:______________ Field:__________________

Occupation:________________________Stay at Home Parent: Y_______ N_________

Work Phone:____________________________ Msg Ok_________

Marital Status:___________Partner Name:_________________________DOB_______

Partner Occupation _______________________________________Years Married_____

Names and ages of children living with you_____________________________________

____

Names and ages of children not living with you_________________________________

____

Names and relationships of others living with you_____________________________

____

Referred By: Name__________________________________Phone________________

Address____

Personal Physician______________________________Phone_______________________

Address____

Major medical illnesses/conditions and dates ____________________________________

____

____

Current Medications:

Medication	Dosage	Prescribed by	Reason

Reasons for seeking treatment at this time ______________________________________

____

____

Have you had previous psychiatric care and/or counseling? Yes_________ No_______

If yes, please give:

Name of Clinician (s)	Reason	How long?

Emergency Contact Information:____

____

Special Concerns:____

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