

CLIENT INTAKE

DATE: _____

Name: _____ Gender : __ Age: __ DOB: __/__/__

Employer: _____ Occupation: _____

Address : _____ City : _____ State : _____ zip : _____

Contact: (hm) _____ (cell) _____ email : _____@_____

Relationship/Marital Status _____

TREATMENT DATA

Referred by: _____

Current Medications? Yes No If yes please specify

Are you currently being treated by a medical practitioner? Yes No

If yes, for what purpose?

Do you have any chronic medical or physical conditions? Yes No

If yes, what are they and how do they affect you?

Have you or someone you are close to ever been concerned about your alcohol or drug use? Yes No

If yes, please explain

What prior experience do you have with counseling or psychotherapy? What has been helpful and what has not been helpful in the past?

What other information would be of value to me in helping you? (Please use back of form if needed)

NOTE: Each counseling session is approximately 50 minutes. If you are unable to keep the scheduled appointment please give 24 hours notice: otherwise a fee will be charged. The only exception is severe emergency.