DEMOGRAPHICS INTAKE

Today's Date: ______________________ Legal Name: ______________________

Preferred Name or Nickname: ______________________

Client's DOB: ______________________ Phone Number: ______________________

Home Address: ______________________

Referral Source: ______________________

Emergency Contacts Phone Number/Name:

______________________ ______________________

______________________ ______________________

Primary Guardian’s First and Last Name: ______________________

Medical Conditions: ______________________

____

Mental Health Diagnosis: ______________________

Allergies: ______________________

Legal Gender (required by insurance): ______________________

Gender Identity: ______________________ Pronouns: ______________________

Reason for Beginning Therapy: ______________________

____

____

____

Current Therapy goals: ____________________

____

____

____

How would you know that therapy was helpful for the client if you look back after the experience?

____

____

On a scale of 1-10 please rate the following related to Client.
(1 represents the lowest amount of disturbance and 10 represent the highest amount.)

Depression: 1 2 3 4 5 6 7 8 9 10

Anxiety: 1 2 3 4 5 6 7 8 9 10

Current Level of Suicidal ideation: 1 2 3 4 5 6 7 8 9 10

Rate your overall level of satisfaction in life: 1 2 3 4 5 6 7 8 9 10

Does the client have a psychiatrist? Yes ☐ No ☐

Name: ____________________

Any history of medical or psychiatric hospitalizations? ____________________
If so, how many and where?

____

____

MEDICAL HISTORY

Primary Care Provider ______________________ Phone Number ______________________

Date of last visit? ______________________

Would you like us to inform your medical provider of the therapy your child receives here? Yes ☐ No ☐

Is there a past or present history of substance abuse? Please explain:

Please list any history of family members with previous mental health diagnosis:

Please list any Prescription Medications: (Include Dosage and Duration):

Please describe the most concerning symptoms client has experienced in the last 3 months.

What would you say is the biggest reason in your opinion your child has been struggling?
Please list any recent triggers.

How could either individual or group therapy be most helpful to your child at this time?

___

___

___

___

Has your child had previous positive or negative experiences with counseling?
If so please describe what was helpful or hurtful in your opinion:

___

___

___

___