

Please print clearly and complete fully.
Patients 16 & older MUST sign all forms
Use Blue or Black ink ONLY



Date: _____
Provider: _____
Revised March 3, 2014

Intake Information **PCN#** _____

Client's Name _____

Parent/Guardian/Legal Representative: _____

Clients Address _____

Apt. _____ City _____ State _____ Zip Code _____

Primary Phone# _____ Phone #2 _____ Phone #3 _____

DOB _____ Social Sec. # _____ Occupation _____ Employer _____

Your Spouse (or if child, Parent or Guardian Information)

Name _____ Address _____

City _____ State _____ Zip Code _____ County _____

Primary Phone #1 _____ Phone #2 _____ Phone #3 _____

Relationship to Client _____ Employer _____

****If patient is under 18-Do you have full custody of child? Yes or No**
If No-please list legal guardian/parent _____
(Legal guardianship paperwork must be provided to the clinic if different from parents)

Reason for seeking counseling at this time: _____

Do you have any serious medical problems or infectious diseases? _____

Marital Status: Single Engaged Married Separated Divorced Widowed Cohabiting For how long? _____

Who Referred You? _____ Religious Affiliation (optional) _____

Race/Ethnicity/Tribe _____ Nation of Origin _____ Length of Time in US _____

Preferred Language _____ Is an interpreter needed for services? _____

Current Medication _____

Names and Dates You Saw In The Past: Psychiatrist, Psychologist, Counselor, and/or Therapist

Emergency Contact: Name and Phone number: _____
(If unable to contact you, who can we call?)