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

Date: ___________
Provider: ___________
Revised 8/31/17

Intake Information

PCN#____________

Client's Name ____

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

Client Information

Address____

Apt. __________ City ______________________ State ____________ Zip Code__________

Primary Phone #1 ______________ Phone #2 ______________ Phone #3______________

DOB __________ Social Sec. #____________Occupation ____________ Employer ______________

Client's Identified Gender and Preferred Pronouns______________________________

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

Name ______________ DOB____________ Address ______________________

City ______________ State ____________ Zip Code __________ County ______________

Primary Phone #1 ______________ Phone #2 ______________ Phone #3______________

Relationship to Client ______________________ Employer ______________________

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 Cohabitating 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:

____

Insurance Company ______________ Policy ID ______________ Group # ______________

Policy Holder ______________ DOB ______________ Social Sec ______________

Address ______________________ City ______________ State __________ Zip Code __________

Contact Phone # ______________ Employer ______________ Relationship to Client ______________

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