



CLIENT INTAKE INFORMATION

Patient Name _____

Marital Status: Single Married Widowed Divorced Separated

If Married, how long? _____ If Divorced, how many times? _____

Presenting Problem(s) State in your own words the reason for which you are requesting to be seen.

Previous counseling, outpatient treatment, substance abuse treatment or hospitalization (please include dates and therapists):

Family Members (Spouse, Children)

Name	Age	Grade/Occupation	Relationship	Living at Home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medications: _____

Physician: _____

Name, Address and Phone

Significant Medical History _____

Client Signature

Date