CLIENT INTAKE INFORMATION

Name:		Date:	
Address:		Home Phone:	
		Work Phone:	
			one:
Email:			
Date of Birth:	Sex:		
Occupation:		_ Employer	· ·
Highest Level of Education	ı:		
School/College Presently A			
	-		
Living Situation: Married			_
Live at s	chool Live w	vith roomma	ate/companion
Please list others living wit	h you:		
Name:	Age:	Relationship:	
Name:	Age:	Relationship:	
		Relationship:	
		Relationship:	
Please list an emergency co	ontact person: (T	Therapist ha	s permission to
contact person listed if an e	emergency arises	s including	the risk of suicidal
behavior)			
Name:	Phone: (home)	(cell)
Relationship to you:			
List any medical/physical p	problems:		
Primary Physician:	an: Last Exam:		
List current medications: _			
Who referred you to this of			
Insurance Company:	Membership Number:		
Policy Holder:	Policy		ployer:
Who referred you to Sharo	n R Peterson?		

Client Intake Information (page 2)

Have you ever had any previous mental health care?				
If so, please list prior clinicians you worked with:				
Briefly state why you are seeking services at this time:				
Have you ever been hospitalized for a mental health condition? If so, please give brief history including when & where you were treated:				
Indicate any issues that apply to you:				
depression				
anxiety (including panic attacks)				
mood swings				
bipolar disorder				
eating disorders				
substance abuse				
impulse control problems				
self-injurious behavior				
suicidal ideation				
parenting issues				
marital/relationship problems				
family history of mental illness				
legal issues				
school/academic problems				
learning disability				
developmentally delayed				
social problems				
ADD or ADHD				
history of physical, sexual, or emotional abuse				
career issues				
financial issues				