THERAPY INTAKE FORM

Client Name: _____

Date of Birth: _____

Contact Information:

Address: _____

Gender: _____

Phone Number: _____

Email: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Insurance Information:

Provider: _____

Policy Number: _____

Group Number: _____

Presenting Problems / Reason for Therapy:

Please describe the main issues, symptoms, or concerns you are seeking therapy for: _____

Mental Health History:

Have you previously received mental health treatment? (Yes/No) _____

If yes, please describe: _____

Medical History:

Are you currently under the care of a physician? (Yes/No) _____

If yes, please specify conditions and medications: _____

Substance Use:

Do you use alcohol, drugs, or tobacco? (Yes/No) _____

If yes, please describe frequency and amount: _____

Safety and Risk Assessment:

Do you have any current thoughts of harming yourself or others? (Yes/No) _____

If yes, please explain: _____

Goals for Therapy:

Please describe your goals and what you hope to achieve through therapy: _____

Client Rights and Consent:

I hereby consent to participate in psychotherapy services provided by the therapist. I understand that the therapist-client relationship is confidential and that information shared during sessions will be kept private in accordance with federal and state laws and ethical guidelines, except where disclosure is required by law. I acknowledge that I have the right to ask questions and discuss any concerns about therapy and that I may withdraw consent and discontinue therapy at any time.

Signature and Date:

Client Signature: _____

Therapist Signature: _____

Printed Name of Therapist: _____

License Number: _____

CLIENT'S SIGNATURE **THERAPIST'S SIGNATURE**

Signature: _____ Signature: _____