CLIENT INTAKE FORM

NAME:_____TODAY'S DATE:_____

DATE OF BIRTH:_____AGE:_____MARITAL STATUS:_____

GENDER:_____ETHNICITY:_____PRONOUNS:_____

PHONE NUMBER(S):_____

EMAIL:_____

PHYSICAL ADDRESS:_____

MAILING ADDRESS:_____

CONTACT PREFERENCES (phone/text/email):_____

EMERGENCY CONTACT & PHONE:_____

EMPLOYMENT / SCHOOL:_____

PRIMARY CARE PHYSICIAN & LOCATION:_____

OTHER PHYSICIANS:_____

MEDICATIONS TAKING:_____

_____

PREVIOUS THERAPY:_____

PRIOR HOSPITALIZATIONS:_____

PRESENTING PROBLEM(S) / REASON FOR THERAPY:_____

_____

_____

WHAT WOULD YOU LIKE TO GET FROM THERAPY? IN WHAT WAYS DO YOU WANT YOUR LIFE TO BE DIFFERENT? _____

_____

_____

_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?
CIRCLE ALL THAT APPLY TO YOU

Depression	Low Energy	Low self-esteem
Poor concentration	Hopelessness	Worthlessness
Guilt	Sleep Disturbance	Weight change
Thoughts of hurting yourself	Thoughts of hurting someone else	Suicidal thoughts
Isolation / social withdrawal	Cutting / burning self	Hallucinations
Hyperactivity	Loss / Grief	Stress
Anxiety	Panic Attacks	Heart pounding / racing
Restlessness	Impulsivity	Anger / Rage
Obsessive thoughts	Compulsive / Excessive behaviors	Racing thoughts
Financial problems	Job performance issues	Easily agitated / irritated
Defies rules	Gambling	Physical abuse issues
Sexual abuse issues	Verbal abuse issues	Alcohol / drug issues
Prescription drug issues	Family / friends concerned about alcohol/drug/medication use	
Loneliness	Sexual problems / issues	Relationship problems
Nightmares	Difficulty with friendships	Paranoia

Do you use / or have history of the following (please describe if applicable):

Nicotine products:_____

Alcohol:_____

_____

Marijuana or illicit drugs:_____

_____

Use of Opioids / Benzos:_____

_____

Is there family history of addiction or mental health diagnoses (please describe if applicable):

_____

_____

Do you have a history of abuse / trauma (describe if applicable):

Physical:

Sexual:

Verbal:

Emotional:

Did you have any birth or developmental issues / traumatic brain injuries (please describe if applicable):

Do you have present (or past) legal or financial issues (please describe if applicable):

_____

_____

Do you have military experience or background (please describe if applicable):

_____

_____

What educational degrees and/or certifications do you have?

_____

_____

Describe your personal strengths:

_____

_____

Describe a personal life challenge:

_____

_____

Please add any additional information that you would like for me to know about:

_____

_____

_____

PLEASE INITIAL IN FRONT OF EACH SECTION AND SIGN AT THE BOTTOM

_____**CONFIDENTIALITY**

Confidentiality is an expectation, and a strong ethical value of counseling. Please know that by law, I am a mandated reporter and legally bound to report child abuse and elder abuse, and/or the intent of grave bodily harm to one's self or another (and the person in threat will be informed). Insurance companies require a mental health diagnosis for filing a claim, and on occasion request a chart review and progress status. If there is any information that you wish to be restricted from your insurance report please discuss with your therapist. In certain cases a court order may supersede confidentiality.

_____**EMERGENCIES**

If you are in a crisis, emergency situation, and/or unsafe with yourself or others call 911. When optional, you can go to your local Emergency Center or free standing psychiatric hospital for services. As appropriate, inform family / significant others / and your therapist of your condition and situation.

_____**FINANCIAL RESPONSIBILITY**

Payment / Co-payment is due in full at time of service. If you need to cancel or reschedule an appointment please do so as soon as possible. For less than a 24 hour notice to cancel or reschedule there is a $45 fee, and for less than a 6 hour notice or a missed appointment there is a $75 fee. The card that you have on file will be charged. I request that all clients have a billing card (credit, debit, health savings, etc.) on file for services and charges. If using insurance, you authorize payment of medical benefits to provider by third party, and authorize the release of information required for payment by third party to Branch Counseling Services (dba Branch Counseling, Inc.).

INFORMED CONSENT FOR TREATMENT

_____I hereby request that (client name) _____
be accepted for psychiatric/mental health treatment, coaching or consulting as described to me. If appropriate/necessary I consent to receive a diagnosis according to the current Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

_____I am freely choosing to enter into treatment and I may discontinue treatment at any time.

_____I understand that I may address any concerns or grievances with my therapist and have the right to contact the licensing board.

SIGNATURE:_____**DATE**:_____

PARENT OR GUARDIAN:

I (name)_____, do hereby state that I am the natural parent or legal guardian of the client, therefore, I am authorized to make this request for and give my consent for treatment and services mentioned in this form.

SIGNATURE:_____**DATE**:_____

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